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ABSTRACT

This report analyzes a program designed to help educate physicians at the residency level in ways of understanding and treating older adults in a context broader than an acute or chronic care setting. The program involves the collaboration between a well-established multi-purpose senior center and a multi-purpose community hospital affiliated with a major medical school and teaching hospital. Program goals included: (1) increased understanding of the psychosocial aspects of health and illness behaviors among the elderly; (2) enhanced appreciation of the concerns and burdens for those caring for elderly patients; (3) developing appropriate communication skills for older patients and their families; and (4) awareness of community resources available to support health among older persons. In all, 11 residents, 9 attending mentors, and 11 social workers and nurses participated in the program during the evaluation period and all were interviewed for the evaluation. Attitudes toward geriatric practice were assessed. The findings suggest that the idea is excellent and the program can be strengthened. Every component of the existing program was regarded as contributing significantly to the program goals, and participants identified a wide range of modifications which would help the program function more effectively. Most of the professionals were willing to learn about geriatric medicine and to treat older people, but they did not wish to be limited to geriatric practice as it is currently defined. The interview forms are attached. (LLL)

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**Final Report**

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# THE SENIOR CENTER SITE FOR GERIATRIC RESIDENCY:

## Evaluation of a Model Program Between

## The North Shore Senior Center and Evanston Hospital

The North Shore Senior Center

7 Happ Road, Northfield, Il. 60093

Ms. Sandi Johnson, LCSW, Director of Social Services

Summer, 1991; Report of October 1, 1991

*The views expressed in the report are those of the author and do not necessarily reflect those of the Gerontological Society of America.*

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## ACKNOWLEDGEMENTS

This report analyzes a very special program designed to help educate physicians at the residency level in ways of understanding and treating older adults in a context broader than an acute or chronic care setting. It is an unusual program involving the collaboration between a well-established multi-purpose senior center and a multi-purpose community hospital affiliated with a major medical school and teaching hospital. The program is intended to be special for those fortunate enough to participate in it, but it is also intended to serve as a model for similar collaborative programs. This special program, and this assessment of the first year of the program reflects the contributions of creative and dedicated people.

First and foremost, the design and analysis of the program reflects the vision and dedication of the professionals at the North Shore Senior Center. *Ms. Sandi Johnson*, LCSW, Director of Social Services at the Center had a major hand in working out the Senior Center components that constitute the program, and she was wise enough to apply to The Gerontological Society of America for one of the Technical Assistance Program grants to underwrite this systematic evaluation of the progress of the program. It has been a pleasure working with her. *Ms. Pat Taylor* has been the energetic Director of the NSSC; long before I knew about this particular program I heard her discuss the need for more imaginative programs to help physicians deal more effectively with elders, and I was not surprised to learn that this program had been developed at her facility. The professional staff at NSSC who were involved with various aspects of this program obviously contributed additional time and energy, both in guiding the physicians through the experiences and cooperating with the evaluation process. *Michele Corrado, R.N.* has been especially involved in scheduling residents and arranging many of the educational experiences. In addition, the following social service staff were most directly involved in the program and were interviewed for the evaluation process: *Sue Carlson, Trudi Davis, Nancy Funk, Dorianne Gitlin, Sandi Johnson, Juli Lamberti, Lois Melvoin, Mary Miller, Geri Sztuk, and Marilyn Vocker.*

This special program also reflects the vision and enterprise of *Bernard Adelson,* M.D., Ph.D., Director of the Geriatric Section of Internal Medicine at Evanston Hospital Department of Medicine. This physician has had a longstanding desire to move geriatric education in the directions of this collaborative program. Fortunately, a grant from the Allstate Foundation to EH encouraged them to proceed with the program. Dr. Adelson has been most gracious in sponsoring crucial assistance to carry out this evaluation. I was provided office space for conducting the personal interviews at the hospital, and he arranged for wonderful support personnel. *Tina Arronis*, the Administrative Assistant in the Geriatric Services Office at EH handled much of the interview scheduling for the resident and mentor physicians; this is a time-consuming job requiring patience and tact, and she handled it with aplomb. *Pam Sykes*, RN, MSN, the Geriatric Program Manager at EH sponsored the program with her interest and her sharing of Tina's time and energy.

A distinctive aspect of the program is the close collaboration between the residents involved in the geriatric rotation and the senior mentor physicians who participated in the experiences

at the NSSC with the residents. These mentor physicians agreed to participate because they believe in the kind of geriatric education it represents, because they are themselves open to learning, and because they felt they could contribute something. They have obviously contributed a great deal to the success of the program thus far, as is evident from the comments of the residents and the NSSC professionals included in this report. The evaluation reported here would not be possible without their cooperation. Each of the nine mentor physicians made time, in very busy schedules, to meet with me for approximately two hours to reflect on the program structure and function and to assess the functioning of each resident. Their perspectives can contributed substantially to our understanding of the challenges involved in guiding the next generation of physicians toward good medical practice. The physicians involved in this project included *Bernard Adelson, Stephen Bundra, Michael Caughron, Kenneth Grumet, Peter Jaggard, David Kuo, John Lindquist, Richard Stalzer, and James Webster.*

Obviously, the research would be quite uninteresting and uninformative without the cooperation of the eleven medical residents who have been through the program thus far. We realize how busy they are, and we much appreciate their time and thoughtful reflections.

The evaluation process benefitted from two unanticipated additions to the research staff. *Grace Kao*, a second-year student at Northwestern University Medical School, received a summer grant from the Buehler Center on Aging at NUMS. Through the sponsorship of Dr. Adelson, she was assigned part-time to assist with this project. In that capacity, Grace helped develop systematic coding schemes for the interview data, coded the data, and prepared it for computer data entry. She also provided additional insights into the process of being socialized into medical practice. Grace tracked down relevant research, and contributed readings from her course on gender issues in medicine. I cherish her participation.

*Mary Doi*, Ph.D. was "in transition" from her doctoral work in anthropology at University of California/San Francisco to Chicago, new home, and first baby (born in September, 1991). When she contacted me, via mutual colleagues, about opportunities to get involved in the "gerontology scene" in Chicago, I invited her to join me in this project and meet some very interesting professionals. She did so, and ended up doing personal interviews with each of the NSSC professionals, working with Grace and me on coding manuals and coding, and discussing the data from her anthropological-systems perspectives. She is also working on some additional data analyses using a computerized text-analysis program she used for her dissertation research on rituals associated with advanced birthdays in Japanese-American families. She has been an unanticipated and wonderful addition to the project.

Finally, our thanks to the GSA for obtaining funding and managing the TAP; the administrators have put a great deal of thought into preparing researchers and agency professionals to appreciate and learn from each other. In our case, *Baila Miller* served as our helpful guide through the GSA procedures.

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## ABSTRACT

# The Senior Center Site for Geriatric Residency: Evaluation of a Model Program

by Margaret Hellie Huyck, Ph.D.
The Gerontological Society of America
1991 Technical Assistance Program

North Shore Senior Center

This project was designed to evaluate the first year of a three-year pilot program in which third medical residents from Evanston Hospital (in Evanston, Il.) were scheduled for one-half day per week during their month-long geriatric rotation into programs at the North Shore Senior Center, or NSSC (in Winnetka, Il.). The broad purpose was to provide experiences with relatively healthy elderly persons, to expand on the hospital and nursing home experiences. In all, 11 residents, 9 attending mentors, and 11 professionals (social workers, nurse) from NSSC have participated thus far, and all were interviewed for this evaluation.

Four specific goals for residents in the program include: (1) Increased understanding of the psychosocial aspects of health and illness behaviors among the elderly; (2) Enhanced appreciation of the concerns and burdens for those caring for elderly patients; (3) Developing appropriate communication skills for older patients and their families, including those with cognitive or hearing impairments; and (4) Awareness of community resources available to support health among older persons. Interview protocols were constructed for assessing the program and rating the competence of the residents on the goals behaviors from the perspective of the three major groups of participants: residents, NSSC professionals, and mentor physicians. In additions, attitudes toward geriatric practice were assessed.

The findings suggest that the idea is excellent and the program can be strengthened. (1) Overall, the professionals involved in this program strongly endorse the concept, and the majority feel that this component of the rotation should be increased. (2) Every component of the existing NSSC program was regarded as contributing significantly to the program goals; the components included participation in the regular structured support and dementia day care programs, the regular services such as home visits, and experiences structured especially for this program, such as the Wellness clinic and reviews of community services. (3) Participants identified a wide range of modifications which would help the program function more effectively, such as increased collaborative planning between the hospital and senior center professionals, clarifying goals and roles, expanding the scope of the program, and revising certain aspects of the program. (4) There is a substantial range of competence among the resident physicians in current functioning in the goal behaviors, from minimal to outstanding. The women residents seem to be more competent dealing with psychosocial issues than are the men. (5) Most of these professionals are willing to learn about geriatric medicine and to treat older people but they do not wish to be limited to geriatric practice as it is currently defined. There is substantial ambivalence about a specialty of geriatric medical practice.

## EXECUTIVE SUMMARY

### Purposes and Procedures

This project was designed to evaluate the first year of a three-year pilot program in which third medical residents from Evanston Hospital (in Evanston, Il.) were scheduled for one-half day per week during their month-long geriatric rotation into programs at the North Shore Senior Center, or NSSC (then in Winnetka, now relocated to Northfield, Il.). The broad purpose was to provide experiences with relatively healthy elderly persons, to expand on the hospital and nursing home experiences.

The pilot program is responsive to the need to recruit, educate, and retain physicians who can work effectively with the growing numbers of elderly women and men. Many experts advise that health care for elders must include psychosocial aspects, and that a collaborative health team approach is the most effective one. Geriatric physicians must learn to interview and take an accurate medical history of an elderly patient that includes such psychosocial history as motivation, morale, family and social interaction, household composition, and productivity; they should be able to identify available social resources and programs in planning the care of an elderly patient, and be able to coordinate and provide for a continuum of care. They must be able to provide personalized and empathic care to patients and their families. This is best done if they are able to coordinate the assessment and management as part of an interdisciplinary health care team (Robbins, Fink, Kosekoff, et. al., 1982). However, most geriatrics training still occurs within nursing homes or acute care settings. A recent survey (Reuben, Fink, Vivell, Hirsch, & Beck, 1990) of a sample of residency training programs in internal medicine and family practice found that none listed a senior center experience as part of the program. Thus, it appears that the NSSC-EH collaboration is a distinctive one, and one clearly responsive to the needs identified by health care experts.

In all, 11 residents (5 women), 9 attending mentors (all men), and 11 professionals (social workers, nurse, all women) from NSSC participated in the program during the evaluation period; all were interviewed for this evaluation.

Four specific goals for residents in the program include: (1) Increased understanding of the psychosocial aspects of health and illness behaviors among the elderly; (2) Enhanced appreciation of the concerns and burdens for those caring for elderly patients; (3) Developing appropriate communication skills for older patients and their families, including those with cognitive or hearing impairments; and (4) Awareness of community resources available to support health among older persons.

The general goals for the evaluation were to provide information for planning by obtaining evaluations of the program from all participants, and to assess the competencies of medical residents in terms of the goal behaviors. In addition, attitudes toward geriatric practice were assessed among the resident and mentor physicians.

## Questions and Findings

The research was addressed to five major questions. The questions and the findings are summarized below.

1. *How do these professionals feel about including a Senior Center component in a geriatric rotation?* Overall, the professionals involved in this program strongly endorse the concept. The NSSC professionals and the mentor physicians are the most positive. The majority of the participants think the NSSC component should be increased. Virtually all the participants feel that the program design and implementation can and should be improved.

This summary statement was derived from responses to questions on a self-report scale, and from responses to interview questions about which components of the program were most valuable and the ways in which this component offers something distinctive in the geriatric rotation. The respondents identified ways in which the program would enhance the functioning of the physicians, contribute to professional team building, break down stereotypes, and even provide supplemental medical care for some of the Senior Center clients.

2. *What aspects of this program should be retained because they contribute to the strength of the program and the accomplishment of specific goals?* Every component of the NSSC program was regarded as contributing significantly to the program goals. These components include participation in the regular structured programs at the NSSC (e.g., the Parkinson's Support Group, the Hearing Impairment Clinic, the House of Welcome (dementia day care); the less formally structured regular services (e.g., home visits); and experiences provided especially for this program (e.g., the Wellness Clinic, reviews of community services, opportunities to discuss cases with mentor physicians and social workers).

This summary statement was derived from responses to interview questions about the aspects of the program which enhanced learning in each of the four goal behaviors.

3. *What modifications would help the program function more effectively?* The program will be strengthened by (1) increasing collaborative planning between the hospital and senior center professionals; (2) clarifying and communicating the goals to all participants; (3) clarifying the roles of participants; (4) considering the expansion of the senior center component of the residency; (5) working out schedule arrangements which would provide the range of opportunities to all residents; (6) structuring the learning experience more; (7) ensuring more adequate "processing" of experiences; (8) expanding the range of experiences available; (9) building in more continuity of interactions between residents, senior center staff, mentors, and clients; (10) rethinking the Wellness Clinic; (11) reconsidering how to learn from the House of Welcome; (12) identifying ways to encourage a stance of enthusiastic, responsible learning among residents; and (13) building in an ongoing process of evaluation, review, and revision.

The summary statement above was drawn from interview questions asking the respondent (1) to identify factors which limited learning in each of the goal behaviors, (2) to indicate what modifications would be desirable to enhance learning in each of the goal areas, and (3) to indicate what other program modifications would be desirable. No particular modification was mentioned by all respondents, and there is disagreement about the optimal design of several aspects of the program.

4. *How competent are the residents in terms of the goal behaviors made explicit after their participation in the program?* There is a substantial range of competence, from minimal to outstanding. On the whole, residents are regarded by themselves, the mentors and the social workers as quite sensitive to psychosocial issues of health and illness and to family caregiver concerns. They seem to be moderately competent in communication skills, and they are largely uninformed about the range of community services available to support health care of the elderly. Women residents were rated as somewhat more sensitive to psychosocial issues than were the men residents.

The summary statement above reflects multiple measures used to estimate the extent to which each resident has developed the attributes and skills considered desirable in a physician working with older adults and their family members and taking advantage of the expertise of other professionals such as social workers. The three measures included:
(a) responses to structured hypotheticals involving an older patient and ability to articulate communication techniques; (2) self ratings of competence in the goal behaviors; and (3) expert observer ratings by mentors and senior center professionals.

5. *How do these professionals view geriatric practice?* Most of these professionals are positive about treating older persons and are willing to do so. Geriatric practice is seen as intellectually challenging and complex. Most are very positive about working with social workers to provide good care for older patients. The physicians perceive varied difficulties with geriatric practice, largely related to inadequate compensation for time-intensive appropriate care. Most prefer to work with adults of all ages, in part to satisfy therapeutic ambitions. There is substantial ambivalence about the desirability and feasibility of encouraging geriatric specialization. Women residents seem to be responding to geriatric practice somewhat differently from the men residents. The (5) women residents were rated more highly by the mentors on psychosocial awareness than were the (6) men, and the women residents were more likely to discuss psychosocial and family caregiver issues in the hypothetical patient example; they were also more likely to feel that the NSSC component of the rotation should be increased.

The summary statement above reflects measures used to assess the ways that the medical residents and mentor physicians, in particular, feel about using their medical skills in the service of older persons. The data includes responses to self-report questions on the 5-point rating scale) and responses to questions posed in the personal interviews.

## Discussion, Limitations, and Implications

The evaluation of the North Shore Senior Center component of the geriatric rotation at Evanston Hospital has affirmed the initial conception. The participants are very positive about the use of a senior center as a setting for geriatric education. The residents feel that many of the programs have contributed to their understanding about the complexities of providing excellent health care to the broad range of non-hospitalized and non-institutionalized older adults. The mentors feel that the residents have benefitted, and often that they have benefitted as well. The social workers and nurse at NSSC are enthusiastic about entering into this more collegial teaching relationship with the physicians.

This report provides a kind of "baseline data" for future evaluations, and has identified some of the relevant dimensions for evaluating such programs.

The primary limitation of this as evaluation research is the post-hoc design, since the goals were defined explicitly only as part of the evaluation process and there was no assessment of the competence of the residents before they entered the geriatric rotation. In addition, the program changed over the course of the year, making it difficult to sum the experiences of participants over the months. While the response rate is exemplary (100%), the absolute numbers are small. The responses of the 31 participants are thoughtful and articulate, and serve as an excellent view of a complex system.

In terms of recruiting and retaining physicians for geriatric practice, the message from this group is clear: physicians are quite willing to learn about geriatric medicine and to treat older people but they do not wish to be limited to geriatric practice as it is currently defined. It is also clear that there must be a major effort to address the issues of adequate compensation for providing more time-intensive geriatric care. The participants in this study make it clear that there are many attractions in trying to understand the complex medical issues and in treating older people.

Two general recommendations are made to the agencies responsible for the program: (1) to build in a systematic, ongoing evaluation process; and (2) to review the modifications suggested by the participants and establish goals and timetables for implementing the desired changes.

## References

Reuben, D.B., Fink, A., Vivell, S., Hirsch, S., & Beck, J. (1990). Geriatrics in residency programs. Academic Medicine: 65(6), 382-387.

Robbins, A.S., Fink, A., Kosecoff, J., et. al. (1982). Studies in geriatric education. I. Developing educational objectives. J. American Geriatric Society, 30(4): 281-288.

## PART 2: RESEARCH REPORT

## 1. INTRODUCTION

### 1.1 The Setting: The Multipurpose North Shore Senior Center in Illinois

This research was designed to evaluate the first year of a three-year pilot program designed to enhance the functioning of geriatric physicians. The program was initiated by the North Shore Senior Center, established in 1956 as a multipurpose senior center serving 19 communities in the northern suburbs around Chicago. The Center includes the typical variety of activities for healthy older residents (lectures, book clubs, social groups, crafts, etc.). In addition, the Center employs professional social workers, nurses, recreation workers, etc. to lead programs in Parkinson's Disease, day care for dementia patients, hearing impairments, case management, counseling, Medicare assistance, etc. The NSSC has produced informative guides to community services, retirement homes, and nursing homes in the area, and they provide information and referral services.

The desire to develop this program grew out of observations with their clients that medical care could be greatly enhanced if the physicians were more aware of some of the non-medical issues affecting health, and if they were more comfortable collaborating with social work professionals in arranging for desirable services available outside the hospital or nursing home.

### 1.2. The Collaborators: Evanston Hospital Physicians

The collaborative program evaluated was developed with Evanston Hospital (EH). EH is a medium-size hospital located in a northern suburb outside of Chicago; it is affiliated with

Northwestern University Medical School and the Northwestern Hospital system. One of the senior physicians at EH had a longstanding interest in developing the geriatric residency program to include broader experiences with ambulatory elders, and had been discussing such a possibility with the director of NSSC for several years. The program came to life in May, 1990 when EH received a grant from the Allstate Foundation to supplement administrative and personnel costs associated with expanding the rotation experience to NSSC.

### 1.3. The NSSC Component of the EH Geriatric Residency Rotation

EH allots one month for third-year medical students to participate in a geriatric medicine rotation. Most of the time is spent in local nursing homes and at EH. EH agreed to schedule residents for one half day per week at NSSC. An attending physician from EH served as a "mentor physician" at each NSSC session; nine physicians have served in this capacity so far.

While at NSSC, the residents and mentors participated in a number of programs, with the schedule arranged by the nurse at NSSC depending on what days were available for the physicians and what activities were available at NSSC at that time. Five structured options included the following.

○ The **Wellness Clinic**, designed especially for this program. A flyer distributed at the Center described "The Wellness Center" as "Doctors and Seniors Learning Together, whereby medical residents with their physician mentors would be at the Center once every week throughout the year, participating in a variety of Senior Center Programs. The Wellness Clinic was described on the flyer in the following way:

> The mutual goals are to help the older adult achieve maximal health through preventive medicine and to positively impact the medical experience of resident physicians.
>
> There is no charge for this opportunity to discuss with the doctor any concerns you may have regarding your health.
>
> Call for your 20 minute appointment: Michele Corrado, R.N. (708) 446-8750

The sessions began as totally unstructured interactions, but evolved to include a set of questions about familiarity with and participation in various preventive health measures; if the client was not participating, they were asked for reasons. The health behaviors include:

| | |
|---|---|
| Tests: | Flu immunization |
| | Pneumovax |
| | Sigmoidoscopy (Proctoscopy) |
| | Stool hemeoccult |
| For Women: | Mammagraphy |
| | Pap smear |
| Other Qs: | Have you seen an opthamologist? |
| | Have you had your hearing tested? |
| | Have you had a tetanus diphtheria booster? |

In addition to the preventive health care questions, clients had opportunities to present whatever health-related concerns the senior felt at the time.

○ **Home visits** with a NSSC social worker. These visits were usually scheduled for 1 1/2 or 2 hours, with time for a briefing on the patient issues by the social worker in charge of the case, traveling to the site, visiting the client in their own home, and some discussion of the experience. Clients covered a range of experiences (e.g., a couple struggling with caring for a seriously impaired husband in a small apartment, a suspected problem of elder abuse, a single elder with limited interactions with medical systems).

○ **Parkinson Disease Support Groups** included sessions with patients themselves and separate sessions for spouses of patients; there is also an exercise program. During these sessions the physicians had opportunities to (1) listen as group members interacted with each other, (2) hear advice specifically aimed at helping physicians deal more effectively with persons struggling with Parkinson's disease, and/or (3) ask questions of members of the group.

○ The **House of Welcome dementia day care program** where visitors could watch, participate in the ongoing activities, observe the transitional times when caregivers came to pick up program participants, and discuss observations with the program staff in charge of the activities.

○ The **Hearing Impairment Groups** include SHHH (Self Help for Hard of Hearing People), Sound-Offs, and Speechreading were arranged for persons with hearing impairments to address their concerns, under the supervision of a social worker skilled in such issues.

In addition to these structured activities, residents had an entry interview with a social worker who went over the materials in the information packet, provided a tour of the general facilities to observe the varied programs in action, and explained the geriatric rotation program; there was also an exit interview with a social worker to discuss experiences.

### 1.4. The Research Challenges: Evaluation and Enhancement

The program officially began in June of 1990, with one student to be assigned to NSSC each month. The NSSC wanted to assess the degree to which the program goals were being met, and to obtain guidelines for revisions of the program.

1.4.1 **Program Goals** The program was designed to enhance the functioning of the resident-level physicians by providing experiences which would lead to:

1. Increased understanding of the psychosocial aspects of health and illness behaviors among the elderly;
2. Enhanced appreciation of the concerns and burdens for family members caring for elderly patients;
3. Developing communication skills appropriate for older patients and their families, including those with hearing or cognitive impairments; and
4. Awareness of community resources available to support elder health care.

1.4.2 **Research Questions** The evaluation was designed to respond to the following research questions:

1. *How do these professionals feel about including a Senior Center component in a geriatric rotation?*
2. *What aspects of this program should be retained because they contribute to the strength of the program?*
3. *What modifications would help the program function more effectively?*
4. *How competent are the medical residents in terms of the goal behaviors made explicit after their participation in the program?*
5. *How do these professionals view geriatric practice?*

Each of these questions will be addressed specifically in Section IV.

## 2. LITERATURE REVIEW

### 2.1 Geriatric Education

There is substantial agreement that much attention should be paid to recruiting, educating, and retaining physicians who can work effectively with the growing numbers of elderly women and men (Vivell, Solomon, & Beck, 1987). Leading geriatricians in the U.S., Canada, and Gt. Britain convened to identify elements in programs which would be responsive to the needs of geriatric medicine (Robbins, Fink, Kosekoff, et. al., 1982). In addition to the medical competencies, the experts noted several particular needs which are addressed by the NSSC-EH program; in fact, the report specifies that physicians "must have educational experiences outside the university in ... senior citizen centers, the patient's home, etc." According to the experts (Robbins, Fink, Kosekoff, et. al., 1982), geriatric physicians must learn to interview and take an accurate medical history of an elderly patient that includes...such psychosocial history as motivation, morale, family and social interaction, household composition, and productivity. They should be able to identify available social resources and programs in planning the care of an elderly patient, and be able to coordinate and provide for a continuum of care. They must be able to provide personalized and empathic care to patients and their families. This is best done if they are able to coordinate the assessment and management as part of an interdisciplinary health care team.

In spite of these recommendations, now nearly a decade in print, there seems to be relatively little progress in developing programs which would help implement these goals. Robbins et. al. (1982) noted that few programs used senior centers as training sites. A recently-published survey (Reuben, Fink, Vivell, Hirsch, & Beck, 1990) of a sample of residency training programs in internal medicine (n=140) and family practice (n=126) found that while the majority of programs included nursing home facilities in a geriatric rotation, none listed a senior center experience as part of the program. Thus, it appears that the NSSC-EH collaboration is a distinctive one, as well as one clearly responsive to needs.

One of the ongoing issues in medical education concerns the timing of specialized training; in particular, should geriatric practice information and experiences be concentrated at the undergraduate medical school level, during the residency, during post-graduate fellowships, or as continuing medical education? (Vivell et al, 1987). Reuben et al (1990) argue that "residency training is perhaps the most pivotal in preparing physicians to practice medicine," since this is the last formal training before practice. In addition, since most care is delivered by physicians without specific training in geriatrics, the residency rotation is perhaps the best opportunity to provide some of the experiences that will prove to be useful in actual practice, when a large proportion of patients are likely to be older. The NSSC-EH program focuses on medical residents, though it may operate informally as ongoing education for some of the mentor physicians as they share new experiences with the residents. In any event, another clear theme is the need to define curricular content and assess how well a program is meeting specific training goals (Reuben et al, 1990), which is an explicit goal of this research.

## 2.2 Program Evaluation

There are several design options for evaluation research (Strecher & Davis, 1987), each with somewhat distinctive strengths and constraints. The most stringent design is experimental, requiring at a minimum assessments before and after program interventions;

ideally, this design should include comparison groups who have not had the program being evaluated. This design may be appropriate for a future study of this program, but was not feasible at this time. Rather, user-oriented and goal-oriented approaches are being used.

The **decision-focused and user-oriented approaches** to program evaluation both stress the importance of working with the client(s) to provide the kinds of information needed to make appropriate decisions about a program. In the **goal-oriented approach** success is measured in terms of program-specific criteria (rather than comparisons with control groups or other programs) (Strecher & Davis, 1987, p 27).

## 3. RESEARCH DESIGN AND METHODS

### 3.1 Respondents

The evaluation process reported here included **all** of the key participants:

○ All 11 of the **medical residents** who participated from June, 1990 through June, 1991 were interviewed. All are in their late 20s or early 30s; 5 are women, 6 are men.

○ All of the nine **mentor physicians** participated; all are men, ranging in experience from four years post-residency to "elder statesmen". Eight of the nine are attending physicians at EH; one has a primary affiliation with Northwestern Medical School. Three of the nine serve as informal coordinators of the geriatric program at EH. In addition to responsibilities at EH (and NSSC), the physicians are medical directors at nursing homes, run private practices, and supervise physicians-in-training at EH. According to the reports, one mentor participated in 7 sessions, three in 5 sessions, two in 4 sessions, one in 3 sessions, and one in two sessions. The mentors are evaluating the program from somewhat different bases of experience and investment.

○ Eleven of the **NSSC social service staff** most directly involved in the educational program also participated in the evaluation process, by both rating the residents and being interviewed personally about their perceptions of the program. This group includes one nurse; the others are social workers or case managers with responsibilities for the in-house programs (the House of Welcome, Parkinsons Support Group, and the hearing impairment groups).

## 3.2 Data Collection Procedures

### 3.2.1 Human Subjects Reviews

The interview schedules and self-report forms were reviewed and approved by the Institutional Review Boards of Evanston Hospital and Illinois Institute of Technology (the university of the P.I., Huyck). A copy of the Informed Consent form is in the Appendix. Each participant was given a copy of the informed consent form.

### 3.2.2 Personal Interviews

The interviews with residents and mentor physicians were conducted by the PI, Margaret Huyck. Interviews were scheduled for two hours; most took somewhat less. Interviews were done privately, most at the staff office at Evanston Hospital; some were done at the physician's office. (One resident had moved out of town and was interviewed in her new office.) Interviewing began in mid-June, 1991 and was completed mid-September, 1991. Although the schedule for this phase of the research was extended because of various schedule conflicts, priority was placed on obtaining responses from all participants.

The senior center professionals were interviewed individually by Mary Doi, a research assistant affiliated with the project. In addition, they met as a group to discuss ratings of the medical residents (see section 3.3.2 (3) below). All interview protocols are in the Appendix.

## 3.3 Measures

### 3.3.1 Information for Planning: Evaluations of the Program

In order to obtain information on how the three groups of participants perceived the program two kinds of measures were used.

(1) A semi-structured **personal interview** was constructed to tap perceptions of the program and personal experiences. (See Appendix) Responses were coded thematically. To establish coding categories, the research assistants and I went over several of the interviews to see what kinds of responses emerged for each questions (e.g.,"What aspects of the program would you modify in order to improve the learning experience?"). After constructing a coding manual, the research assistant went over each interview and coded the responses; this gives us evidence concerning the relative frequency of different kinds of responses. The coding scheme is thus "grounded" in the data, rather than imposed by some a priori assumptions about the kinds of responses which would be important.

(2) The self-report **Personal Attitudes Questionnaire** (PAQ) consisted of 15 statements, to which individuals indicated extent of agreement on a 5-point scale. The statements were varied somewhat for each respondent group (residents, mentors, senior center professionals), and were written to meet the goals of this evaluation. Six of the statements deal with program evaluation. This questionnaire was administered at the end of the personal interview.

### 3.3.2 Goal Attainment: Assessing Resident Competencies

My role in this aspect was to work closely with program staff to help them clarify their thinking about program objectives and procedures for measuring their attainment. After reading written materials describing the program goals, I met with the NSSC program director (Sandi Johnson, MSW), with the group of NSSC professionals, with the coordinator of the EH program (Bernard Adelson, MD, PhD), and with several of the attending mentor physicians to discuss their view of the program goals. On the basis of these discussions, Ms. Johnson and I articulated four goals to be evaluated.

Each of these goals involve increasing the medical resident's competence in (1) understanding the psychosocial aspects of health and illness behaviors among the elderly, (2) appreciating the concerns and burdens for those caring for elderly patients, (3) communicating effectively with older patients and their families, including persons with cognitive or hearing impairments, and (4) being aware of community resources available to support health among older persons.

This aspect of the research was designed primarily to assess the current level of functioning in the group of 11 residents who have participated in the program thus far. The assessment of competence relies on multiple estimates, obtained from (1) resident responses to hypothetical patient situations, (2) resident self-ratings of competence, and (3) expert observer ratings of each resident obtained from the mentor physicians and senior center professionals. Each of these estimates is described below.

(1) **Resident responses to hypothetical patients** One set of estimates of competence was derived from the residents themselves, during personal interviews; these measures include (a) resident responses to a standardized (hypothetical) patient description (provided by a mentor physician), with their responses coded for sensitivity to psychosocial and caregiver issues; and (b) resident responses to questions on how they modify communication for

hearing or cognitively-impaired older persons, with responses coded in terms of guidelines taught at the NSSC.

(2) **Resident self-ratings on the goal behaviors** Following their responses to the hypothetical patient situations, each resident was asked specifically to rate him/herself on each of the goal behaviors, including their estimates of competence before their geriatric rotation, currently, and anticipated competence in five years. They were also asked to describe what they had in mind when making ratings of their current competence.

(3) **Expert observer ratings** Another set of measures are derived from expert observer ratings made by the NSSC professional staff who interacted with the residents, and by the attending mentor physicians who accompanied residents during the half-day sessions.

Because each resident was seen by a few to several of the **social work/nursing staff** at NSSC, and because the interactions have occurred over the past year, special steps had to be taken to help the NSSC staff recollect the resident behaviors. The session was held during a staff session, on Tuesday, June 4, 1991; from 2:45-5:00. All but one of the staff who have interacted with the residents were present; in addition, some of the other social work staff members who have not been directly involved in the program so far attended. A total of some 20 staff members were there. The project director (Huyck) and a new research associate, Mary Doi, Ph.D., were there. To prepare for the session, the staff mounted pictures of the 11 resident physicians on cards, so that staff members could better recall the participants. Three sets of rating forms for each resident were duplicated; sticky notes with names were used, and then replaced by code numbers. Small pieces of paper were provided for individual ratings.

Each resident was rated on the four goal behaviors. The nurse in charge of this aspect of the program reviewed the participation record for the resident, indicating in which programs she/he had participated, and with whom. I reviewed each goal behavior in turn, and asked for observations about the behaviors from anyone who had any contact with the resident. Most of the observations were drawn from interactions within the NSSC program, though some of the raters had additional experiences with the residents at Evanston Hospital; all observations were noted in an effort to gain the fullest picture of the resident's functioning. Notes, as nearly verbatim as possible, were taken by Huyck, Doi, and Johnson; this provides a reliability check. After the group discussion, individuals who felt familiar enough with the resident made an independent rating of the resident on each of the four goal behaviors. These ratings were collected and noted on the rating sheets; this provides the distribution of ratings, the average, and the number of raters. There was substantial variability in the number of persons who felt comfortable making any observation or a rating on a particular resident, with a minimum of one to a maximum of 6.

Similar ratings of residents were obtained from the **mentor physicians** for those residents they accompanied. Each mentor rated the current competence in each goal behavior of each resident they had observed, using a 5-point scale, and to give examples of behaviors.

### 3.3.3 Attitudes toward Geriatric Practice

Attitudes toward geriatric practice generally, and more specifically about collaborating with social workers and about geriatric specialization, were assessed from eight questions on the PAQ (Personal Attitude Questionnaire) and from questions in the personal interview. The specific questions used are noted in Section IV. 4.5 below.

# 4. RESEARCH QUESTIONS, FINDINGS, AND EVIDENCE

## 4.1 Question #1 *How do these professionals feel about including a Senior Center component in a geriatric rotation?*

### 4.1.1 Findings

**Overall, the professionals involved in this program strongly endorse the concept. The NSSC professionals and the mentor physicians are the most positive. The majority of the participants think that the NSSC component of the rotation should be increased. Virtually all the participants feel that the program design and implementation can and should be improved.**

### 4.1.2 Evidence

This summary statement was derived most directly from responses to specific questions on a self-report questionnaire. Evidence is also contained in responses to interview questions about which components of the program were most valuable, and the ways in which this component offers something distinctive in the geriatric rotation.

Table 1 provides the responses of the residents, mentors, and senior center professionals to the six statements assessing general attitudes toward the program. This table indicates the number from each group who endorsed each point of the agreement scale, as well as the average agreement for each group. All of the mentor physicians, all of the senior center professionals, and all but one of the residents **agreed** (or strongly agreed) with the statement *"The NSSC/EH program is a good idea for geriatric education."* Average endorsements were 5.0 (strongly agree) for the senior center professionals, 4.8 for the mentor physicians, and 4.2 for the residents. Nearly all the participants indicated that they felt fortunate to have participated in the NSSC pilot program, that participation was a good use of their time, and that they would encourage others to take this geriatric rotation. Most **disagreed** with the statement that *"An internist has too many medical things to learn to bother about becoming familiar with community resources and family functioning."* Ratings were somewhat lower for the statement *"The program was well designed to meet the goals."* The graphs show the distribution of responses for some of these questions.

### TABLE 1

### ATTITUDES TOWARD THE SENIOR CENTER COMPONENT IN THE GERIATRIC ROTATION

(Average agreement with statement, where 1 = Disagree Strongly, 5 = Agree Strongly)

| Statement | Residents | Mentors | NSSC |
|---|---|---|---|
| The NSSC/EH program is a good idea for geriatric education. | 4.2 | 4.8 | 5.0 |
| An internist has too many medical things to learn to bother about becoming familiar with community resources and family functioning. | 1.7 | 1.1 | 1.0 |
| I will encourage others to elect the geriatric rotation. | 4.1 | 4.6 | |
| [I think all internists should take the geriatric rotation.] | | | 4.9 |
| The NSSC experiences should be a larger part of the rotation. | 3.7 | 3.2 | 4.5 |
| I feel fortunate to have participated in the NSSC pilot program. | 4.1 | 4.7 | 4.6 |
| The program was well designed to meet the goals. | 3.6 | 3.7 | 4.0 |
| Serving as a mentor has been a good use of my time. | | 4.6 | 4.9 |
| My mentors were good role models. | 4.3 | | |

Note: Alternate forms of some questions were used to make them appropriate for the group.

## Figure 1

"The NSCC/EH Program is a Good Idea for Geriatric Education" Agreement among Medical Residents, Mentor Physicians, and Social Serivce Professionals

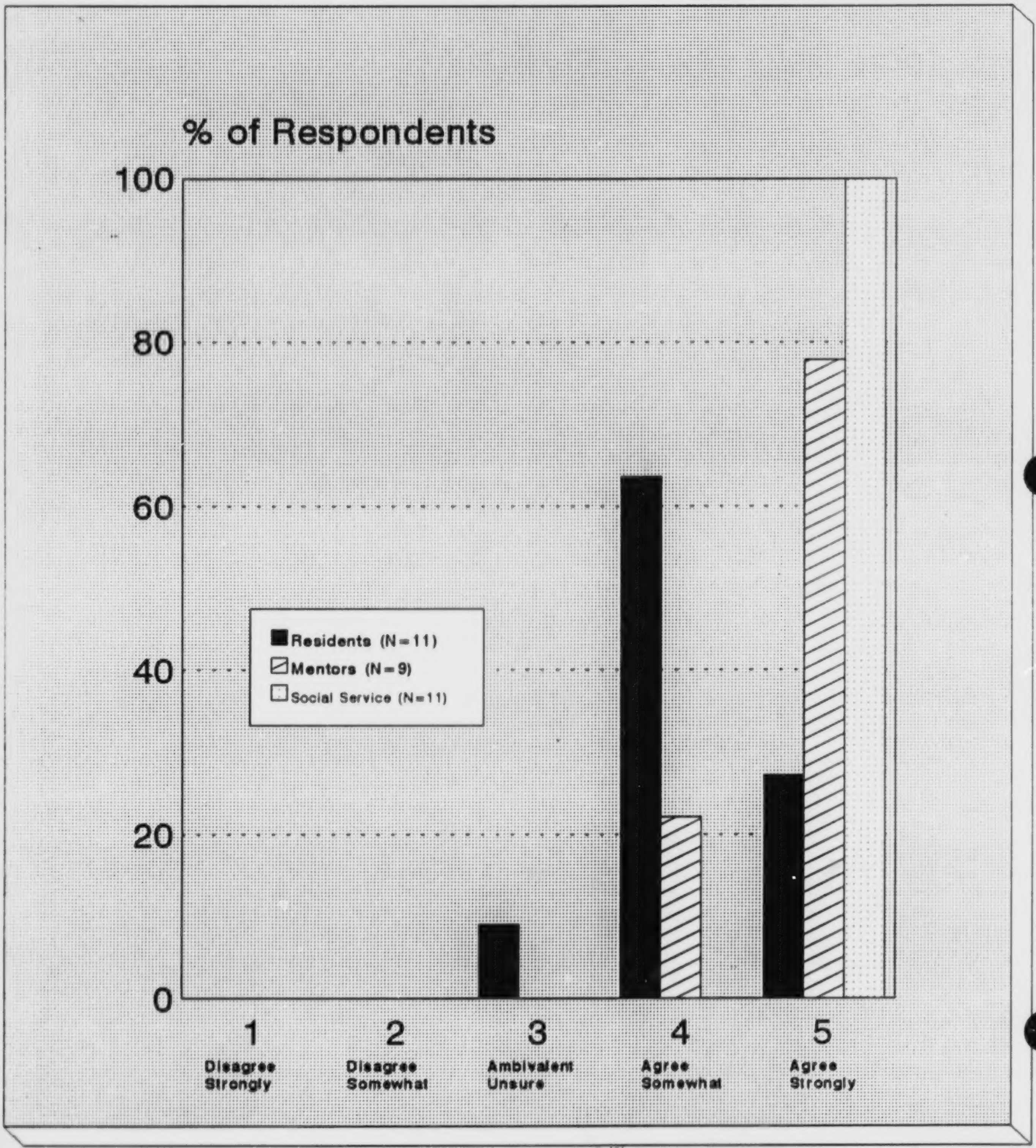
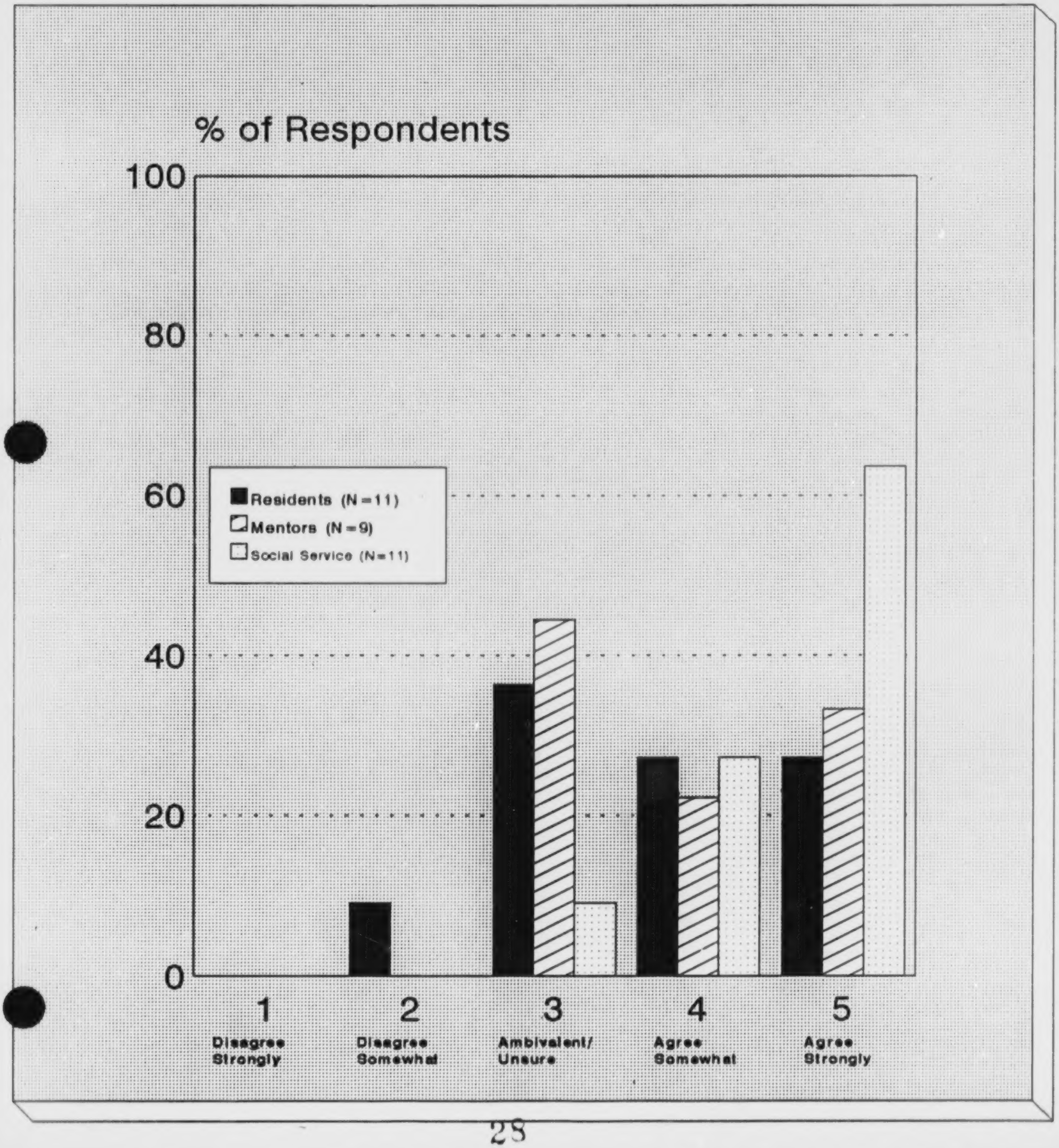


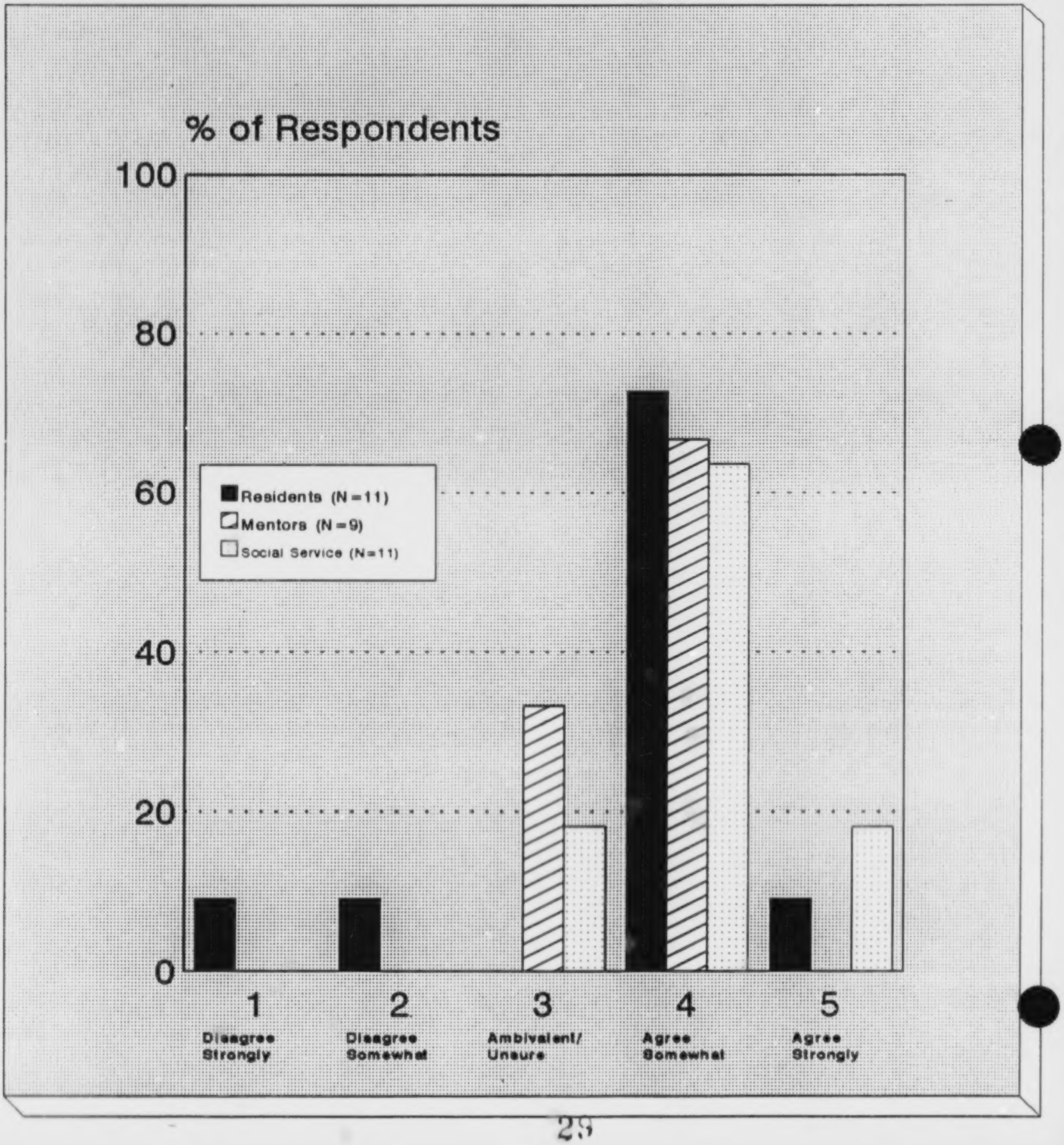
Figure 2

"The NSCC Experiences Should be a Larger Part of the Rotation"
Agreement among Medical Residents, Mentor Physicians, and Social Service Professionals



# Figure 3

## "The program was well designed to meet the goals" Responses of Medical Residents, Mentor Physicians, and Social Service Professionals



In response to the question *"What are the most valuable aspects of this program"* many of the participants described ways in which the program would **enhance the functioning of the physicians**. The specific ways mentioned included the following:

- ○ Learning to listen and learn from the patient;
- ○ Learning the importance of remaining at home rather than automatically assuming that nursing home placement is desirable;
- ○ Learning to relax about the "Dr." role;
- ○ "Humanizing" the patient by interacting more on the patient's own terms and in the patient's own space on home visits;
- ○ Realizing they may not retain patients if their interactions are unsatisfactory, particularly if the patients are hearing-impaired;
- ○ Watching mentors interact with patients;
- ○ Making informed referrals to services.

**Professional team-building** was identified as one of the most valuable aspects by several participants. This includes greater understanding of what social workers do (for the physicians) and what physicians do (for the social workers). It also includes the important sense that the mentor physicians, especially, recognize and validate the professional expertise of the senior center professionals. In some cases, this took the form of reassuring the senior center professionals that what they were doing was, indeed, appropriate; or that the best care reasonable was being provided. In other cases, this team-building was reflected in the appreciation that the physicians were able to explain issues to the senior center professionals.

**Breaking down stereotypes** was a theme mentioned by half of the residents, several social workers, and one mentor physician. These responses included:

- ○ Seeing healthy older people and consumers of health care taking more responsibility for their own health;
- ○ Getting behind the "glorified" stereotype of the North Shore;
- ○ Realizing that there are physicians who are personable and caring.

Some of the participants, particularly the senior center professionals, indicated that a substantial, unanticipated "bonus" of the program was in **providing supplemental medical care** for NSSC clients, some of whom had resisted any medical contacts and who were essentially out of the regular network of medical care. This was particularly an issue for some of the clients included in the home visits.

## 4.2 Question #2 *What aspects of this program should be retained because they contribute to the strength of the program and the accomplishment of specific goals?*

### 4.2.1 Findings

**Every component of the NSSC was regarded by the majority of participants as contributing significantly to the program goals. These components include participation in the regular structured programs at the NSSC (e.g., the Parkinson's Support Group, the programs for the hearing impaired, the House of Welcome (dementia day care); the less formally-structured regular services (e.g., home visits); and experiences provided especially for this program (e.g., the Wellness Clinic, reviews of community services, opportunities to discuss cases with mentor physicians and social workers).**

### 4.2.2 What enhances understanding of psychosocial issues and family caregiver concerns?

(1) **Regular structured experiences** clearly contributed. Most of the participants identified the Parkinson's Disease patient and family support groups, the home visits with a nurse or social worker, and other support groups as extremely valuable in developing an appreciation of how individuals and families cope with illness. The following are examples of how participants responded to the questions about which experiences in the program helped develop sensitivity to psychosocial aspects of health and illness or understanding of family caregiver concerns.

> "All of the programs-- because of the interaction with the people in more of a psychosocial than medical role. You're not there as a physician. And the social workers stress those things." (Resident)

> "The Parkinson support group gave me a lot of insight into the difficulties in being married to a patient. The main thing was talking to patients in a non-hospital setting, and not having to be there as a doctor; people just aren't themselves with an M.D., so I tried to be just an observer. I had more to learn than contribute. If you are the Doctor, people expect you to have all the answers, and you don't learn as much that way." (Resident)

> "During the home visit you can see just how dependent and debilitated a patient is, and how unsophisticated a home setting is. They can also see the specific problems of a home setting, such as the layout of the house, or the career goals of the caregiver, the caregiver's own poor health, or even a situation where the patient is unwilling to get medical attention. The residents see things they wouldn't see otherwise, and some of the mentors are superb in helping them understand and model good ways of responding." (Social worker)

> "At the House of Welcome we saw individuals of all ages. In our practice we can get fooled about our patients' cognitive abilities, but when you spend an hour with them you realize how they are limited." (Resident)

> "The Wellness Clinic, because after each encounter I'd discuss the case with the resident and focus in on the special needs of the person **beyond** the medicine. That was my opportunity to show the resident the more subtle, non-medical issues." (Mentor)

(2) Several programs provided opportunities for the resident physicians to gain a better understanding of **how patients view their physicians**. The Parkinson and hearing impaired groups, and Wellness Clinic consultations were particularly mentioned by the residents.

> "I'd never seen a place that offered so much support to the elderly. Listening to people in the clinics and support groups, I could understand that they had a lot of problems with their doctors, when there was not enough time to answer questions, or they didn't ask the right questions. I decided I don't want to be a doctor who hurries them through the process; you have to take more time." (Resident)

(3) **Experiences outside the rotation** were identified as explicitly important by several residents and mentors. In particular, family experiences with frail elders were often mentioned as important prior occasions for learning about psychosocial issues in illness and family care. (This might be considered the "grandparent factor"...)

> "My grandparents supplied me with some experience; the NSSC with more. I have an elderly grandmother who has long lived with us, so I know how hard it is. My grandmother is impossible; I have no answers, but I know how difficult it is. When she first moved in she was pretty demented. My grandmother goes to a day care program. And my husband's grandmother finally died last year. We visited her in the nursing home, and we watched them deal with the guilt over putting her in the home. And I have a 95 year old grandfather who lives independently, apart from his demented wife. I see how concerned his family is about how he can manage, and how to let him be as independent as he wants and still be safe." (Resident)

### 4.2.3 What enhances appropriate communications skills?

(1) **Structured programs** were sometimes helpful. The Hard of Hearing program (SHHH) was enthusiastically endorsed by the (relatively few) residents who participated in it. The House of Welcome (dementia day care program) was seen as moderately helpful by some participants, in providing opportunities to practice communication skills, to observe more closely the kinds of cognitive deficits revealed in activities such as pie-making or game-playing, and to observe social workers and mentors communicating effectively. The Wellness Clinic consultations were regarded as useful by some, providing opportunities for more intensive interactions with clients than is usual.

(2) Several residents explicitly identified the **general opportunities to interact** with older persons and to **observe mentors and the NSSC professionals interacting** with the elders, as important in developing their communication skills.

(3) Several participants, mentors and senior center professionals, indicated that they thought the residents who showed good communication skills arrived with them; they implied that nothing in the program itself enhanced their competence level.

### 4.2.4 What factors enhance the awareness of community services to support medical care?

(1) Most of the residents mentioned the **orientation** session, during which they were shown around the Senior Center and the varied programs ongoing. Several mentioned the **packet of information** about community services, though most also admitted that they had not read the materials at the time. Some of the residents who were entering private practice in the area indicated that the packet materials were extremely valuable, and they had obtained additional copies and information from the Center.

(2) **Home visits and support groups** provided some opportunities to discuss services utilized or needed, both with the client and with the supervising social worker.

(3) Several residents mentioned that the **evaluation interview**, in which they were asked to assess their familiarity with 20 different elder services, was very enlightening--and motivated them to seek further information.

### 4.3 Question #3: *What modifications would help the program function more effectively?*

#### 4.3.1 Findings

**The program will be strengthened by (1) increasing collaborative planning between the hospital and senior center professionals; (2) clarifying and communicating the goals to all participants; (3) clarifying the roles of participants; (4) considering the expansion of the senior center component of the residency; (5) working out schedule arrangements which would provide the range of opportunities to all residents; (6) structuring the learning experience more; (7) ensuring more adequate "processing" of experiences; (8) expanding the range of experiences available; (9) building in more continuity of interactions between residents, senior center staff, mentors, and clients; (10) rethinking the Wellness Clinic; (11) reconsidering how to learn from the House of Welcome; (12) identifying ways to encourage a stance of enthusiastic, responsible learning among residents; and (13) building in an ongoing process of evaluation, review, and revision.**

4.3.2 Evidence The summary statement above was drawn from interview questions asking the respondent (1) to identify factors which limited learning in each of the goal behaviors, (2) to indicate what modifications would be desirable to enhance learning in each of the goal areas, and (3) to indicate what other program modifications would be desirable. Most of the respondents had suggestions for modifications; these have been grouped thematically below to facilitate discussion.

#### 4.3.3 Revisions Suggested By Participants

No particular modification was mentioned by all respondents, and there is disagreement about the optimal design of several aspects of the program. My attempt is to present a balanced picture of the responses, as information for those who are charged with implementing and revising the program in the near future.

## (1) Increase the collaborative planning between Evanston Hospital and NSSC professionals.

This modification seems central to all others, since the program success relies heavily on shared communication and support from both institutional sponsors. The most crucial form of collaborative planning will probably focus on clarifying goals and roles. At a more instrumental level, both organizations have complex schedules into which to fit resident experiences, and there must be coordination and advance planning. In addition, issues of financial and other kinds of support need to be addressed.

One of the problems during the first year was the limited staff time available for coordination and collaborative planning. This seems to be a particular problem at EH, since the head of the program at the hospital has only 10% officially delegated to the geriatric residency program (overall); governance is shared by a triad of dedicated mentor physicians, but no one has the clear authority and time to assume responsibility for coordinating complex matters with NSSC. This is an organizational problem, quite apart from the content of the program, but must be addressed if the program is to thrive.

## (2) Clarify and communicate program goals

The goals described here were implicit in what the initial organizers said and wrote; they were made explicit for this evaluation process. Most respondents indicated that if they had been clear about the goals at the outset, they would have been more intentional and focused in their instruction, learning, and evaluations. For example, the social workers said they could have planned home visits for their value as teaching experiences to illustrate family caregiving, service utilization, etc.

## (3) Clarify the roles of the participants

Many of the participants indicated that they were unclear, particularly at first, about what they were supposed to be doing in that setting and in the relationships, since they were somewhat different from those associated with their usual practice. Some responded to this uncertainty with anxiety and resentment, some with psychological distancing (probably also related to anxiety), some with attempts to structure the situations into a more familiar form, and some with a surprised openness to learning something new While the underlying issues seem to be similar for the various participants, each of the groups seem to have particular issues which reflect their status in the larger system.

The **residents** were most unclear about whether they should be an "observer" or an "actor" in the senior center situations. They perceive themselves to be junior-level physicians, which means they need instruction, practice, and encouragement. Some of the residents indicated that they felt thwarted particularly by mentor physicians who "took over" and did all the talking (in the Wellness Clinic or home visits, for example), thus depriving the resident of a valuable opportunity to practice their emerging skills; these residents wished the mentors to be less the "doctor" and more the teacher providing feedback to the resident after the interaction was completed. On the other hand, some residents indicated that they appreciated the opportunities to be the observer and to learn by watching a skillful mentor physician or social worker in action. The discomfort was probably most acute in the House of Welcome, where residents were unclear whether they should be a group participant, and learn by interacting with group members, or an observer and learn by monitoring the professional-client and client-family interactions.

The **mentor physicians** did not often mention a subjective sense of discomfort with their role. However, questions about their role were discussed by the residents and the senior center staff members. The underlying issue seems to be the extent to which the physicians present themselves as (1) the primary expert and teacher, (2) the primary "facilitator" for the resident's active participation, or (3) as a co-learner with the resident (with the senior center professionals providing specialized knowledge and feedback to both physicians). These are not, of course, mutually exclusive; the most esteemed mentors seemed to be appropriately flexible in each of these styles.

An additional issue raised was the degree of specialization modeled:

> "The mentors could improve the learning situation if they could broach more of the psychosocial problems, to give a more integrated view with the psychosocial issues. As it was, the social workers handled the psychosocial and the attendings talked medicine; it would be better to have a more integrated analysis from the attendings." (Resident)

Several mentors also noted that it was very important for the senior physicians to model desirable behavior by being informed about support services and contributions of the social work professionals; information presented and affirmed only by the social workers tend to be "blown off" by the residents, according to these mentors.

The **senior center professionals** (clinical social workers and a nurse) were very articulate in expressing their desire to know whether they should be seen -- and act -- as equal colleagues in the teaching enterprise. If their role is defined as an important member of the teaching team, most indicated they would feel comfortable taking more initiative in pointing out things they thought the resident should be learning and observing. However, some felt that initiative on their part was considered inappropriate by either the mentors or the residents; they felt, rather, that they were regarded as "secondary" or "auxiliary" professionals. Insofar as the social work professionals feel inhibited in sharing their special expertise, the program will be weakened, since one of the distinctive features of the program is to provide substantial contact with these professionals.

## (4) Increase the time allocated to this component of the geriatric rotation.

Two questions tapped the issue of time allocated to the NSSC component. During the interview, respondents were asked whether the time should be decreased, remain the same, or be increased. In addition, the self-report questionnaire scale included the statement, "The NSSC should be a larger part of the rotation."

The majority of participants recommended **increasing** the time for this (or an expanded) program. On the self-report scale, ten of the (11) NSSC professionals, 6 of the (11) residents, and 5 of the (9) mentors recommended increasing the time. The reasons given by the physicians included:

> "Add at least a half day more, in the afternoon, rather than being at the Presbyterian Home so much. There were afternoons when there wasn't enough to do there, and we should be learning about the things you have covered in this interview." (several Residents)
>
> "I got a lot out of certain things, and there is too much time at the nursing homes. I don't need to be doing more physicals; I do that in the clinic. We should have **all** the programs, and learn more about the programs and services." (Resident)
>
> "We don't need so much on nursing homes. We have enough inpatient. Private practice is 90% outpatient, and we need to see issues that affect them. It would be good to go to more of the Wellness Clinics." (Resident)

> "It would be useful to have more time if we had more varied things. We can't get too deep; the value of the program is exposure." (Resident)
>
> "The program has depth and resources we haven't really tapped." (Mentor)
>
> "It would be good to have more than one exposure to home visits and support groups, since the first one is a shock; you can be a better participant the second time." (Mentor)
>
> "It's more interesting. It has the potential to be more captivating to residents as future geriatricians. It's the same as oncology: inpatient is awful, and outpatient is fun because you see people dealing with their illness well. You need to see older people as **people**, not just as patients. I'd like to see **half** time spent at the NSSC or something like it." (Mentor)

Almost half of the mentors and residents recommended **leaving the time allocation as it is**. Rationales reflect the balance of competing demands and presumed needs:

> "It's adequate. The issues dealt with at the Senior Center will constitute about 10% of their practice when the residents get out. So I'd mostly tighten it up, and do more home visits, less House of Welcome, more didactic teaching, more consultations with the social workers. But not more time." (Mentor)

One resident recommended **decreasing** the time spent on the NSSC component. This resident was distinctive in having participated in a very similar program in medical school, and he felt the NSSC experience was redundant and a distraction from enhancing more clearly medical competencies. As he said,

> "Internal medicine is very complex. We need more on the medicine, less on the holistic stuff. I don't want to miss a dermatology diagnosis because I've been doing all this other stuff." (Resident)

### (5) Arrange the schedules to ensure that all residents have the available experiences.

One of the major problems has been the impossibility of ensuring that each resident participated in the opportunities to develop the competencies desired. Each month one half day was selected for the resident and mentor to come to the Senior Center. Some of the most valuable programs run once a week, but not necessarily on the day schedules. The experiences available were thus unpredictable. For example, only a few of the residents attended the groups for the hearing impaired; those who did found them very informative, and those who only heard about them indicated they wished they had the opportunity. Every resident who attended the Parkinson support or patient group indicated that this had been a very valuable experience, but not all residents had this experience.

Several options seem available, and were suggested by participants:

(a) Increase the overall amount of time allocated to the senior center programs.

(b) Schedule the assignment to cover all days of the week.

(c) Schedule well in advance so the Center can plan for appropriate clients and experiences.

### (6) Structure the learning experiences to be more didactic.

Generally, there are two broad models of learning: instructional or dietetic, and experiential or guided discovery. **Didactic**, structured, or instructional learning approaches emphasize the clear articulation of learning goals, direct instruction in the points to be mastered, and rehearsal of information to be mastered. **Experiential** learning is more indirect; the focus is on immersing the learner in a situation, and then guiding the individual to identify what has been observed, what is not clearly understood, and how the current experiences challenge or confirm prior conceptions.

In each approach, the "teacher" and the "learner" play somewhat different roles. In the didactic approach, the teacher is regarded as the expert and is responsible for presenting a succinct, coherent summary of materials to be mastered. In the experiential approach, the teacher acts more as a facilitator, setting up experiences which are likely to lead to observations and insights by the learner; the teacher also serves as a crucial "reflecting point" to help the learner process the experiences and discover what he/she has learned.

Both approaches have been shown to be effective modes of learning, with the effectiveness depending on the learners, the teachers, and the subject matter covered. Our interest here is not on which method is "correct", but on identifying the strategies which may enhance the learning experience for physicians at the residency level of learning.

It appears that the program was set up initially on a model of experiential learning. That is, it was apparently assumed that residents who accompanied a clinical social worker on a home visit would make their own observations and process them sufficiently with the mentor physician and/or the social worker to glean the important "learnings." Similarly, it was assumed that residents who visited the House of Welcome dementia day care program would know what to observe and how to put what they observed into a framework of understanding about cognitive functioning, needs of the cognitively impaired, dilemmas and burdens confronting persons caring for demented elders, and possibilities for appropriate care and intervention for all involved.

However, it seems clear that many of the residents and mentors are unfamiliar with and even uncomfortable with the extent to which the learning was unstructured. Thus, many of the physicians suggested ways in which the teaching/learning experience could be made more structured and dietetic, and more concordant with what they experience in the rest of their medical education. These suggestions included:

(a) Having a panel presentation to describe different support services and community programs, and pointing out where they are described in the information materials.

(b) Have a quiz on the services.

(c) Hand out brief readings.

(d) Make sure that residents receive written materials on how to interact effectively with the hearing-impaired and cognitively-impaired persons.

(e) Have a demonstration of hearing-assistive devices.

(f) Have the social worker in charge of the House of Welcome give a short lecture about what to look for in assessing kinds of impairment with dementia, and why the program is set up as it is.

(g) Provide a lecture summarizing psychosocial and caregiver issues.

(h) Give the resident a checklist of psychosocial things to consider before making a home visit, so they will be sure to not miss anything.

(i) Videotape an interaction of the resident and a client, and critique it with the resident, mentor physician and social worker to improve communication competence.

(j) Have each resident prepare a special "public information" lecture on a topic of interest to the senior center members.

Not all residents and mentors recommended more didactic structure. Several residents said they liked the relatively unstructured approach, which gave them the opportunity to either observe or actively participate and draw their own conclusions. As one resident said:

> "I learned the most by observation. I didn't need formal teaching by then. The social workers were very good in giving informal feedback, and that's how I learn best." (Resident)

Two residents changed their mind over time; as one explained:

> "Initially I had some questions about the Wellness Clinic in an otherwise excellent program. People seemed to come in to second-guess their doctor, or just to talk, or to talk about one thing when something else was the real problem. But now I think that was probably the best experience to illustrate the psychosocial issues. I recall one instance where a woman came in and talked for about 25 minutes about some problem, and when I was trying to wrap it up she finally blurted out 'But what am I going to do about my 45-year-old retarded son?' That was her real problem; the other one was just some way to make contact. It made me realize more of the complexity. So the very unstructured approach does have its strengths." (Resident)

### (7) Ensure more adequate "processing" of experiences.

This suggestion was offered by residents, mentors, and senior center professionals. Many of the participants felt that they did not have enough time to discuss what had been experienced and what could be learned; sometimes the problem arose because the resident or mentor (or both) were late in arriving, or rushed off immediately following a session. This was a particular problem with the home visits. The pre-visit "briefings" by the social worker were seen as very helpful, and the residents indicated that a post-session discussion would also be useful. Several of the residents explicitly said that they wished they had more opportunity to discuss the case issues, services, etc. with the social worker and mentor.

## (8) Expand the range of experiences available.

These are suggestions to build upon the existing strengths of the program by adding comparable but different experiences. These included:

(1) Expand the geographic area to include more diverse cases.

(2) Visit other senior centers, particularly in urban, poorer neighborhoods.

(3) Visit more of the community support programs listed in the Directory.

(4) Visit a public aid nursing home.

(5) Have a lecture/demo from a Medicare form processor.

(6) Provide information about service costs and financing options.

(7) Discuss discharge planning process with a social worker.

(8) Participate in a case analysis with the social worker and mentor.

(9) Have the social workers and physicians participate in the same courses, so they can learn what each specialist does, and can be a better collaborator.

(10) Have more direct interactions with family caregivers; one-on-one.

(11) Talk with more of the family members providing care.

(12) Have a "Wellness Clinic" where a caregiver, resident and attending could talk about caregiving issues, preferably more than one on session.

(13) Work through the referral process with a social worker.

(14) Provide information on advance directives.

(15) Visit a vision-impairment support group.

## (9) Build in more continuity of interactions between residents, NSSC staff, mentors, and clients.

Several residents and mentors expressed their concern that it was hard to learn how to really assess the evolution of illness and coping strategies, though this is one of the potential benefits of working within a facility like the Senior Center. Several specific suggestions were offered, while acknowledging time pressures and scheduling problems.

(1) Repeat experiences with the same clients or groups; for example making at least one repeat visit to a home care client or to the Parkinson support group.

(2) Spread a case study over several weeks or, preferably, months.

## (10) Rethink the Wellness Clinic

The Wellness Clinic is the single most problematic component. This was developed specifically for the geriatric rotation, as an opportunity for personal interaction with a Senior Center member who wished to discuss some health issue with the resident and the mentor physician. Twenty minute appointments are scheduled. In part, the comments reflect the evolution of this component over the first year. The Clinic began as a very unstructured interaction, with the client structuring the interaction to a great extent. Over the year, in response to comments from the residents and the mentors, it has become structured to the extent that each Clinic consultation includes a short interview about common preventive health measures.

Participants identified a number of **strengths** in the Wellness Clinic.

> "The Wellness Clinic helped me understand that patients may leave the doctor with a lot of questions. So it's good to ask if they have any questions." (Resident)
>
> "In the Wellness Clinic you may have a 'young' 80-year-old and an 'old' 80-year-old, and I had to think about altering my communication to talk on different levels. It was good practice." (Resident)
>
> "The Wellness Clinic was very good because I saw the mentors deal very well with other doctor's patients. They gave good advice, and answered some difficult questions." (Resident)
>
> "I was fortunate to visit the Parkinson group, and then later the son of one of the Parkinson group members came to the Wellness Clinic and explained how he was caring for his father, and what changes had occurred. That whole exchange was very helpful. I could really see the whole system." (Resident)
>
> "I thought the Wellness Clinic went well. It can give the resident a sense of your role as educating the patient, rather than treating. It was difficult to figure out how to avoid just giving a second opinion. But internists are giving more counseling, so they need to feel comfortable doing it." (Mentor)
>
> "Some of the residents felt like a ship at sea without a sail in the Wellness Clinic; perhaps we need to give them some guideposts as to what to explore. But it's an interesting setting because you get people you're not necessarily beholden to. They come and they often don't know why they came, and you have to figure out why. It's frustrating, but out of that comes better skills in interviewing and understanding." (Mentor)

Participants also perceived **problems** with the Clinic.

> "The Wellness Clinic people were silly, or just complaining about their own doctor. This one woman -- it was really her own problem. I know the doctor she complained about." (Resident)
>
> "The Wellness Clinic wasn't a good experience. I wasn't sure what the goal was. We just referred them back to their own doctor." (Resident)
>
> "Some of the people who came to Clinic really had nothing to say. You should screen them to be sure they really have a problem." (Resident)

> 'The Wellness Clinic was the least effective part of the program. When you are dealing with tertiary care you can turn the residents off. They are doing bone marrow procedures and dealing with other complex, life-threatening health problems. If you backpedal too much, you lose them. The home visits were good because they hit you in the eye. The preventive questions in the Wellness Clinic are good, but you need to screen what's coming in...I'm really busy, and sometimes I felt it wasn't really a good use of my time.They have their own doctors. Maybe they get reassurance, but then you don't have any followup. The contrast between the laid back discussions there and the really crucial medical problems the residents and doctors confront elsewhere is too great. Efficiency is important, and that's really not an efficient use of time." (Mentor)
>
> "The Wellness Clinic should be modified or made optional. Maybe we could offer a clinic around a given topic, like cholesterol levels: give a lecture and offer the Wellness Clinic after that to answer questions. We could do sessions on arthritis, heart attack recovery, advanced directives." (Mentor)

## (11) Reconsider how to learn from the House of Welcome.

The House of Welcome is a day care program for persons with dementia. It accommodates approximately 8 clients at a time in an old house. The facility is directed by a social worker and staffed by an occupational therapist, a nurse, and activity workers. Activities occur in the kitchen, the living room, or in the other small areas. Thus, there is no formal "observation area" apart from the group activities. A number of participants in the programs felt uncomfortable about how to "be" in that space, and how to relate to the clients. Generally, the social service staff seemed to expect the visitor/observers (residents and mentor physicians) to join in whatever activities were ongoing, such as game playing or cake baking. However, it was clear that some of the residents and some of the mentors were very uncomfortable with this, and questioned the usefulness of spending much time here.

Several residents identified important learning experiences from the longer, more unstructured interactions with clients in the House of Welcome. As one said,

> "The dementia program was the most valuable experience helping me understand the psychosocial aspects. I got there late, and they had just baked a cake. I could really see the range of dementia. It was a nice change to see it directly, and where everyone was coming from. Also, I remember playing a game of dice; one lady couldn't count, and another lovely, elegant lady just couldn't figure out when her turn was." (Resident)

At the other extreme:

> "They get a lot of dementia in the nursing home, so they certainly don't need to spend a lot of time there. It's enough to just show them the program briefly and explain what goes on there." (Mentor)

### (12) Identify ways to encourage a stance of enthusiastic, responsible learning among the residents.

When asked to identify factors which limited the learning of the goal behaviors, one of the most common responses reflected concerns about the intended "learners"--the residents. All of these participants recognize the stress and time demands on the young physicians. The residents themselves admitted that they often had not learned what was available because they felt overwhelmed, some by family problems rather than work, and were not open to the kinds of learning offered. In any event, their ambivalence or even resistance toward the program was expressed in lateness, last minute cancellations, and disinterest on the part of some residents.

Mentors were occasionally mentioned as problems, in terms of lateness, absence or difficulty in responding to the social workers as professional colleagues. Besides providing a poor model for the residents, these make it very difficult to carry out the program as planned.

### (13) Build in an ongoing evaluation process.

This point returns essentially to the first needed modification -- to enhance the collaborative planning between the hospital and the senior center professionals.

The evaluation of the program thus far indicates that this is a superior idea, well conceptualized and responsive to the felt needs of most of the mentor physicians and social workers, and many of the residents. The clear sense is that this is an excellent start on a complex, imaginative addition to geriatric education. However, the many suggestions offered to strengthen the program also make it clear that the program should continue to evolve. The program will necessarily change, partly in response to the new physical location of the NSSC, perhaps in response to requirements that all internal medicine residencies include geriatrics, and perhaps in response to changes in the personnel available to devote the extra energy needed to make the program succeed.

One of the primary goals of this evaluation is to assess how much impact the program is having on the residents. The assessment of "program impact" is difficult, at best, since the residents are undergoing many experiences. However, at a minimum we need comparisons "before" and "after" the senior center experience. Evaluations should be carried out soon after the experience.

It is also likely that the process of clarifying goals and developing measures appropriate for use in ongoing evaluation will direct attention to these goals and increase the likelihood that the goals will be met.

One of the goals of this evaluation is to assess the functioning of the residents; our "after the fact" assessments will be presented next.

## 4.4 Question #4: *How competent are the residents in terms of the goal behaviors made explicit after their participation in the program?*

### 4.4.1 Findings

**There is a substantial range of competence, from minimal to outstanding. On the whole, residents are regarded by themselves, the mentors and the social workers as quite sensitive to psychosocial issues of health and illness and to family caregiver concerns. They seem to be moderately competent in communication skills, and they are largely uninformed about the range of community services available to support health care of the elderly. Women residents were rated as somewhat more sensitive to psychosocial issues than were the men residents.**

4.4.2 Evidence The summary statement above reflects multiple measures used to estimate the extent to which each resident has developed the attributes and skills considered desirable in a physician working with older adults and their family members and taking advantage of the expertise of other professionals such as social workers. The three measures included: (a) responses to structured hypotheticals involving an older patient and ability to articulate communication techniques; (2) self ratings of competence in the goal behaviors; and (3) expert observer ratings by mentors and senior center professionals.

(Details about the measures and data collection are given in Section 3.2.2 above; rating scales are in the interviews in the Appendix.)

## (1) Residents are substantially more likely to identify medical issues than psychosocial issues when discussing a hypothetical elderly woman patient in the care of her daughter.

In order to estimate how the resident might approach an actual patient assessment, one of the mentor physicians prepared a description of a hypothetical 81-year-old woman patient. The following information was provided to the resident during the interview; they could study the sheet as long as they wished.

### Patient Discussion

An 81-year old woman is brought in to your office, accompanied by her daughter, because of general decline. The daughter states that she has taken care of her mother in her own home for the past nine years since the patient's husband died suddenly. The woman has had mild "senility" for several years, but in the last few months she has suddenly become increasingly forgetful. She has occasionally left food burning on the stove when left alone. She gets up at night, at times agitated and screaming, and attempts to leave the house to look for her husband. She has fallen several times. She now needs help with bathing and dressing.

She has a history of hypertension and mild congestive heart failure. She takes hydrochlorothiazide, potassium, digoxin and enalspril. She does not complain of chest pain or shortness of breath. She occasionally drinks alcohol, which the daughter has in the house.

The daughter would like you to recommend a way to control her mother's nocturnal behavior. She would like to "avoid a lot of tests" because of limited finances. She was divorced last year at age 54, and had to quit her part-time job when her mother began deteriorating. Her brother and sister live in another state. Her children are married but try to help when possible.

On exam, the patient is disoriented and somewhat anxious, but in no acute distress. BP 170/100; P 70 and regular. General exam is remarkable only for an S 4 and some scattered ecchymoses on her shoulders, back and arms, in various stages of healing. Neurologic exam shows no focal abnormalities. She has a normal gait and balance exam and negative Romberg. Folstein Mini-Mental score = 22/30.

Labs: CBC, T4, TSH, B12, folate, PT, PTT, platelets, bleed time - WNL.
SMAC - WNL except LDH 240. Digoxin < 0.5.

After being given a chance to study the patient description, the resident was asked *"What diagnostic possibilities come to mind in this case? How would you check out these possibilities?"* I asked several times if they had any other thoughts in mind. If nothing but medical issues were addressed, I asked, *"Is there anything you would want to know about the family situation before you made your assessments and recommended a treatment plan?"*

The desirable responses were listed by the mentor physician who prepared the example, as the kinds of issues he would consider in such a case. Residents were evaluated in terms of their competency for this task on the extent to which they recognized some of the more psychosocial issues involved in this situation. As Table 2 indicates, virtually all (10 of the 11) residents mentioned the possibility of Alzheimers Disease and indicated they would want a CT scan or an MRI; over half also mentioned the possibility of stroke or inappropriate medications. Less than half of the residents, even when prompted, thought of elder abuse, alcohol misuse, or caregiver issues.

**TABLE 2**

**PATIENT ASSESSMENT ISSUES IDENTIFIED BY RESIDENTS**

| Possibility | Percent | N |
|---|---|---|
| Alzheimer's type dementia | 91.9% | 10 |
| Give CT scan/ MRI | 91.9 | 10 |
| Small-stroke syndrome/multi-infarct dementia | 72.7 | 8 |
| Inappropriate medication use or lack thereof | 63.6 | 7 |
| Subdural hematoma | 45.5 | 5 |
| Elder abuse | 45.5 | 5 |
| Suggest investigating options for respite care | 45.5 | 5 |
| Home assessment for social isolation | 45.5 | 5 |
| Discuss with daughter privately whether she is feeling undue stress | 36.4 | 4 |
| Alcohol amnestic disorder | 27.3 | 3 |
| Caregiver stress syndrome | 27.3 | 3 |
| Discuss with patient (or daughter) privately how she got bruises | 27.3 | 3 |
| Assess home for safety | 27.3 | 3 |
| Check all medications | 27.3 | 3 |
| Give daughter permission to meet her own needs | 18.2 | 2 |
| Home check for environmental barriers | 18.2 | 2 |
| Discuss with daughter how to maximize mom's functioning | - 0 | 0 |

The most reasonable conclusion seems to be that at this point in their professional development the medical residents do not easily or automatically include a broad range of potentially-relevant variables in thinking about particular patients. It is possible that the wording of the initial questions suggested the more narrowly-medical/diagnostic issues to the residents. Future evaluations could include more than one example, and probe more specifically for the range of issues considered.

(2) **Residents see themselves as more competent than they were before the geriatric rotation but less competent than they will be in five years. Residents are more confident of their competence in psychosocial aspects and communication skills, and less confident about their knowledge of support services. The residents and the mentors generally are congruent on assessing the competence of the resident in psychosocial issues and sensitivity to family caregiver concerns; the senior center professionals are more varied in their ratings.**

As part of the personal interview, residents were asked to rate themselves on the goal behaviors established for the program. The residents were given the following instructions:

> *As you may have gathered, the collaborative program between NSSC and EH was designed to meet certain educational goals. I am going to describe some of these goals to you, and ask you to rate yourself on these dimensions. First, I will ask you to think back before you started your geriatric rotation, and rate yourself as of then. Second, think about now, after you have completed your geriatric rotation. And finally, I will ask you to think about how skillful you will be in another 5 years.*

*In making your ratings, use the following scale from 1 to 5:*

1 = **Realistically, I was (or am now) not comfortable with these issues. I don't know enough to feel competent in including these into my medical practice.**

3 = **I'm reasonably competent in these areas, but at least some of the time I feel unsure about what to consider or do. I have a general idea of how to incorporate these into my medical practice.**

5 = **I am very confident that I have included these aspects into my medical practice. I would feel comfortable modeling these behaviors for others.**

Table 3 shows the average ratings of competence in each of the goal behaviors for the 11 residents, rating themselves before they took the geriatric rotation, at the time of the interview (after the rotation), and how they expected to be functioning in five years; for the mentors rating the residents; and for the NSSC professionals rating the residents.

TABLE 3

RATINGS OF MEDICAL RESIDENTS AT NSSC ON GOAL BEHAVIORS

(Average Ratings, where 1 = low and 5 = high competence)

| Goal Behavior | Resident Self Ratings Past | Resident Self Ratings Current | Resident Self Ratings Future | Mentors Ratings | NSSC Ratings |
|---|---|---|---|---|---|
| Understanding of Psychosocial Issues | 2.7 | 3.7 | 4.3 | 3.7 | 3.3 |
| Sensitivity to Family Caregivers | 2.9 | 3.7 | 4.6 | 3.5 | 3.3 |
| Communication Skills | 2.9 | 3.4 | 4.3 | 3.8 | 3.6 |
| Familiarity with Support Services | 1.6 | 2.7 | 4.1 | 3.1 | 3.3 |

(3) **Residents, mentors, and senior center professionals rate the residents as showing moderate to substantial sensitivity to psychosocial issues in health care of elders and to family caregiver concerns. Mentors rate women residents higher than men on awareness of psychosocial issues.**

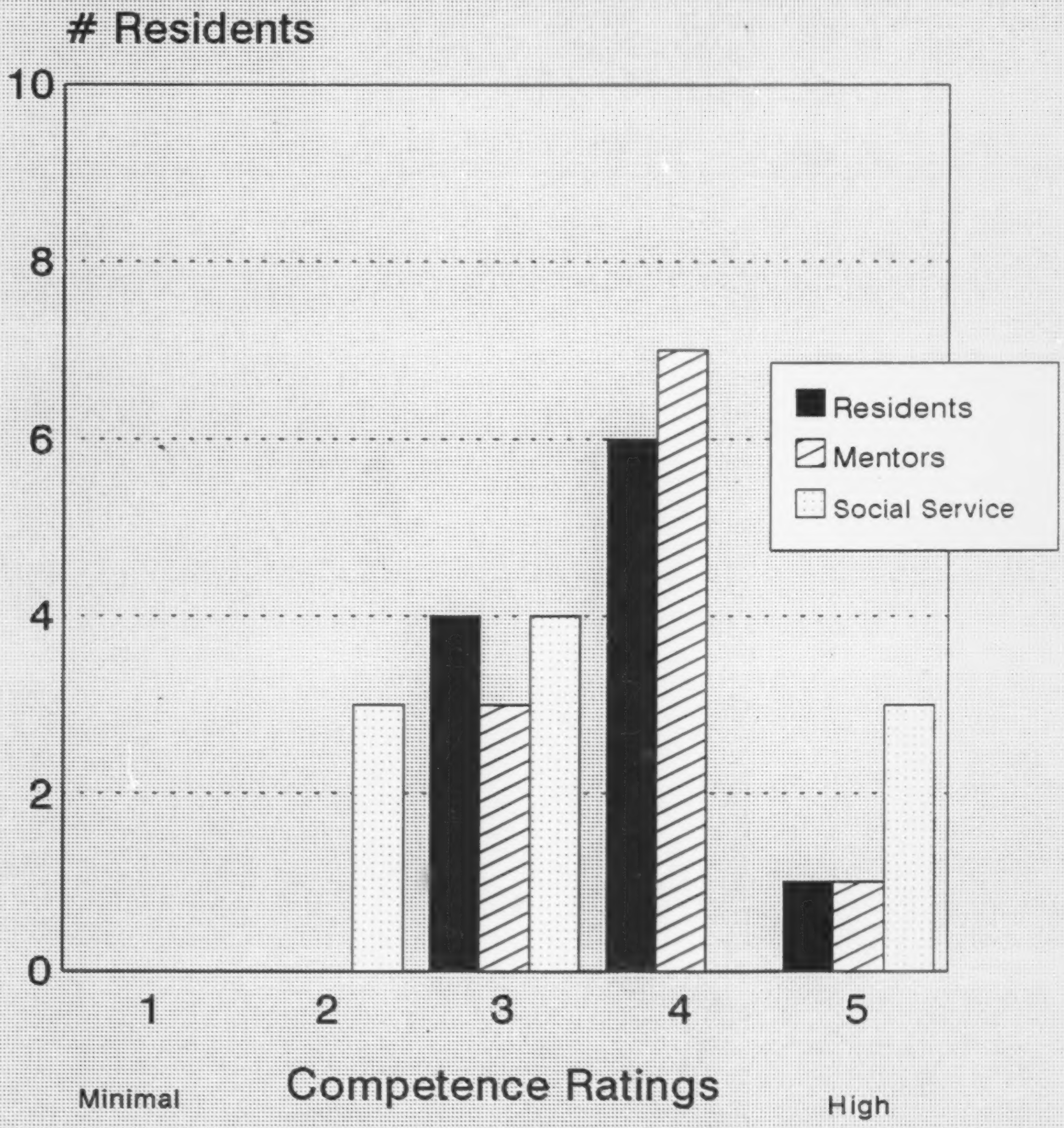
Residents rated themselves an average of 3.7 (SD .6) on this 5-point scale on both understanding of psychosocial issues of health and illness among older adults, and on sensitivity to family caregiver concerns. They rated themselves as having been lower on these competencies before taking the geriatric residency (2.7 on psychosocial and 2.9 on caregiver); and they anticipated improving in the next five years (4.6 on caregiver and 4.3 on psychosocial). These ratings are shown in Table 3.

During their personal interviews, the mentor physicians were asked to rate each of the residents with whom they had worked, on the basis of NSSC experiences or other contacts. The same 5-point rating scale was used, but only for current level of functioning. In addition, the professional staff at the senior center rated the residents using this scale for their estimates of current functioning. The mentors rated the residents an average of 3.7 on psychosocial issues and 3.5 on family caregiver concerns; the social workers gave the residents an average rating of 3.3 in each of these domains.

As shown in Figure 4, there was considerable variability in the ratings. Some of the young physicians are regarded, by themselves and by others, as showing excellent understanding of the complexities of caring for older patients. They are seen as knowledgeable about the medical complexities and also comfortable with the special concerns and characteristics of the elder and the family system.

Figure 4

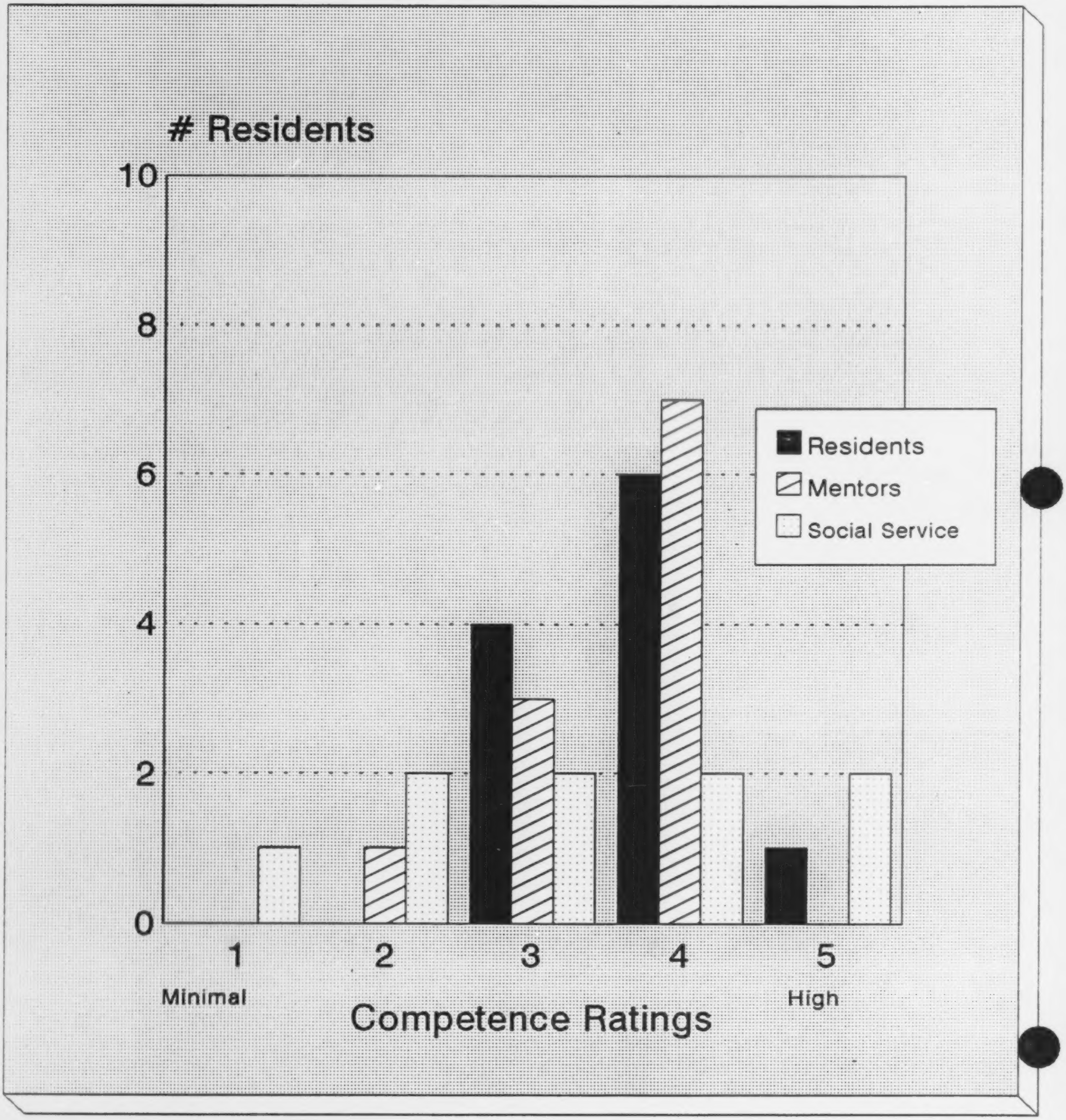
Awareness of Psychosocial Issues in Illness Among Older Persons: Current Competence Rated by Resident, Mentor Physicians, and Social Service Professionals



Ratings for Mentors and Social Service are averages for that group.

## Figure 5

### Sensitivity to Family Caregiver Concerns: Current Competence of Geriatric Residents Rated by Resident, Mentor Physicians and Senior Center Professionals



Ratings from Mentors and Social Service Professionals are averages for the group.

The following are descriptions of one of the residents, in response to the question *"Can you think of examples to illustrate your rating?"*

> "I always try to think of those [psychosocial issues]. I try to think of what their home situation is. For instance, my grandmother-in-law, the best thing for her is to keep her at home, even though she's having a lot of trouble with her memory. So I think of my patients like how would this be if this were my grandmother? Sometimes people ask me, when I argue to leave her at home, "What if she fell down and died?" I respond, 'Well, she'd be happy she died at home, at 85.' I think it's better to leave them at home as long as possible." (Resident, rated self 4 now, 3 before, 5 future)
>
> "On the home visit the mentor gave her the opportunity to ask questions and she asked very good questions; she seemed to care about health and psychological functioning." "She is self confident and interested, and interacted a lot in the House of Welcome." "She related very well to the support group members." (Social workers, gave average rating of 4.8 to Resident described)
>
> "I've seen her interact with elders and families under conditions of great stress; she's very tolerant of stressful interviews and that is important in geriatrics. She also has such a genuinely cheerful affect that she's like a tonic. And I've worked with her when we had patients unable to make decisions about their care and were at a real crossroads. She was helpful in aiding the caregivers to explore those issues and feelings." (Mentor, rated Resident 4)
>
> "I've had a lot of contact with her. She relates very well with old people, and makes them feel comfortable. I can picture her sitting there holding a hand. I can't think of anything special in terms of caregiver concerns, but I rated her 4 just based on her overall competence. Everything starts with accurate medical diagnosis; you can't be really sensitive about these other things if you don't understand the underlying medical issues and what the family members may have to deal with realistically." (Mentor)

Other residents are evidently having more difficulty integrating these aspects into their practice. The following all describe one of the residents who was seen as less consistent and given ratings of 2 to 5 on sensitivity to psychosocial issues and family caregiver concerns.

> "I can think of a lot of examples [of how I am sensitive to psychosocial issues]. I have an elderly clinic patient who has trouble seeing and hearing. She doesn't take her meds because she can't see the labels and forgets. Another can't come see me unless she has special transportation, so I set that up. (So compliance behaviors are anchored in other aspects?) Yes, that's what I was thinking." (Resident, rated self 4 now, 3 earlier, 4 or 5 future on psychosocial issues)
>
> "On caregiver concerns, I learned a lot on the rotation. We did a home visit to a debilitated man and saw how his wife dealt with it. And the caregiver support group for Parkinson's -- that was a great learning experience. I wasn't as familiar before." (Resident, rated self 3 now, 2 earlier, ? future on caregiver concerns)
>
> "I've worked very closely with him. He's a very sensitive individual who is interested in ethics, patient autonomy, justice, and fairness, and he approaches patients with that view." (Mentor, rated Resident 5 on psychosocial)
>
> "At times he showed a genuine concern for the patients; other times he showed blunted affect. He's very involved in ethical issues, but his behavior seems very cold at times. He comes across with some very blunt remarks. In terms of caregiving, at times I thought he was really concerned, but he didn't express it. He was very inconsistent. Gutwise, I'd rate him a 3, but on behavior he's a 2." (Mentor, rated Resident 3 on psychosocial, 2 on caregiver concerns)
>
> "He didn't know what he was doing and he didn't ask appropriate questions. He was very touched by the Parkinson group, but he only expressed his distress in his notes." "The Resident asked about the family on the home visit, but he couldn't understand why the family struggled to keep the elder out of a nursing home." "He showed no sensitivity in the House of Welcome; he stood aloof and bored, out of it." "There were no outward signs of any sensitivity." "He had a poor attitude, just doing it because it was required." (Social workers, gave Resident average rating of 1.6)

The quotes above suggest another finding: **The Mentors rated the women residents higher in sensitivity to psychosocial issues than they did the men residents.** The mean for the women was 4.0 (SD .5) and for men 3.4 (SD .4); using a T-Test, this difference was significant at $p<.03$. (This means that a difference this great would occur only 3 times out of a 100 by chance.) However, neither the residents themselves or the social workers differed in their ratings by gender.

It is also evident even from these selective quotes that the raters used a variety of criteria to evaluate competence in these areas. This is, of course, a problem with any numeric rating scale. The senior center professionals are distinctive in rating some residents as less competent and others as more competent than do the physicians. The physicians' ratings tend to cluster near the middle to middle-high range. It is not clear why these different perceptions prevail.

### (4) The residents are regarded as moderately competent in communication skills. Residents rate themselves lower on these skills than do their mentors or the social workers. Residents seem better able to demonstrate sensitive communication than to articulate necessary modifications to communicate well with persons who have hearing or cognitive impairments.

One of the purposes in undertaking the program was to enhance the abilities of the resident physicians in communicating clearly and appropriately with older patients and their families. As one of the mentors pointed out, there are two important aspects of communication. One involves understanding the "subtext" of the patient's concerns, by listening with the "third ear." In this research, such sensitivity has probably been coded more as understanding of psychosocial issues and sensitivity to family caregiver concerns. The second component of communication involves knowledge of special techniques for communicating with the hearing impaired or cognitively impaired; it is this dimension that is tapped most directly in the measure of "communication competence."

During the personal interviews, residents were asked several questions about hypothetical situations involving older patients and how they would modify their regular communication patterns to take account of differing patient capacities to receive and process spoken communication. These questions included:

> *Many older persons have some hearing impairments. If you suspect, or know, that you are communicating with a person with a hearing impairment, how do you alter your behavior?*
>
> *Some older patients suffer with dementia. Communicating with these patients is often a challenge for physicians. How do you alter your normal communication style when you are dealing with a person who has mild to severe dementia?*
>
> *Sometimes it's difficult to know whether your communication has been clear. How do you check whether your intended message has gotten through to your older patient?*

Responses were scored according to whether the resident mentioned the guidelines mentioned in material handed out by the hearing-impairment support group (SHHH) and the House of Welcome dementia group at NSSC. It should be noted, however, that relatively few of the residents had received these helpful written materials; they are now being included in the information packets given to the physicians.

Most of the residents gave some rules, mostly about getting closer, speaking more slowly and clearly, repeating the message, writing things down, and asking questions to check for understanding. However, it was clear that none of the residents were able to articulate the full range of guidelines for ensuring clear communication with older patients, and some recommended strategies which are contraindicated (such as speaking more loudly, talking to a relative who understands and bypassing the patient, repeating the initial message without modifying it if it seems to be not understood). After the interview, I showed the residents the list of suggested guidelines, and most were genuinely surprised that there were such explicit guidelines; most also indicated they would like to have these presented during the rotation and would find them useful.

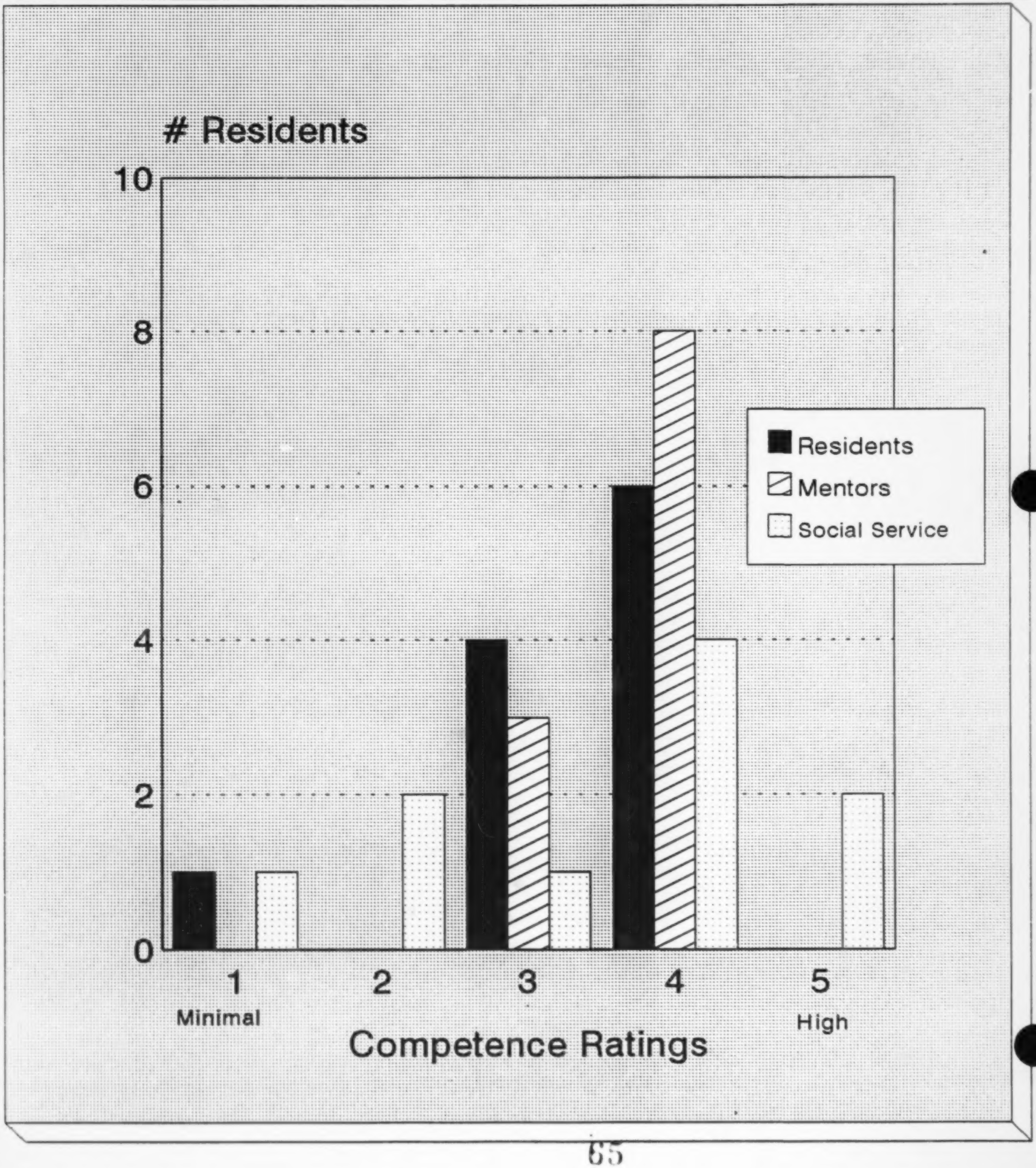
A second method of estimating their competence in communication skills was derived from ratings, using the same 5-point scale used for assessing awareness of psychosocial issues and sensitivity to family caregiver concerns. [See (2) above] As noted in Table 3, residents rated themselves, on the average, as 3.4 in current skills, an improvement over the 2.9 before the geriatric rotation and less than the 4.3 they expected to achieve in 5 years. The mentor physicians gave the residents an average rating of 3.8; the social workers 3.6.

Figure 6 shows the distribution of ratings on this dimension.

As with the ratings for awareness of psychosocial issues and caregiver concerns, the numerical ratings seem to reflect somewhat varied criteria.

> "What I do most of the day is communicate. I learned more through experience, seeing what works, watching mentors interact appropriately and modeling their behavior. Most patients are impaired in some way. In fact, the elderly are less impaired than most of my hospital patients." (Resident, rated self 4 current, 4 past, ? future)
>
> "He communicates well, though he does not always look like a doctor. Physicians need to be neat, clean, combed -- and he sometimes looks like a harassed graduate student." (Mentor, rating resident quoted above a 4 on communication skills)
>
> "He initiated no interactions." "He should go into research." (Social workers rating resident above 1.5 on communication skills)
>
> "I deal with a lot of people who are hearing impaired and I wonder if there is more I could be doing. I ask them what they understand." (Resident who rated herself as 3/4 currently, 2 before rotation, and expects to be 4/5 in five years)
>
> "She speaks clearly and has an expressive face. Her voice is clear and she uses it." (Mentor rating above resident with 5 on communication)
>
> "She certainly is sensitive to the hearing impaired but her language was still very technical. Sometimes she talked to them like babies." (Mentor rating above resident 3 on communication skills)
>
> "I don't know of any deficiencies, and on the basis of her general competence I'd rate her a 4 on communication." (Mentor rating resident above)

Figure 6
Communications Skills
Current Competence of Geriatric Residents Rated by Resident, Mentor Physicians and Senior Center Professionals



> "She was able to relate to wherever the patient was, and didn't talk down." "She put people at ease. She seemed to have good eye contact, was relaxed, and had no hesitation." "I'm not sure how well she listened; she always knew the answers." (Senior Center professionals rating resident above, with average of 4.5)
>
> "She has a clear voice. Good listener. Projects compassion." (Mentor rating a resident 5 on communication skills)

The sense that emerges from the examples given is that the expert raters, and the residents themselves, are responding to the varied aspects of what constitute good communication skills. Future evaluations should perhaps identify the components of communication skills more clearly, for educational and evaluation purposes.

### (5) Residents, mentors and senior center professionals agree that the residents are most deficient in familiarity with community and social services which can support the health care of older persons.

One way we assessed the extent to which residents were familiar with the range of community and social services available to health care workers was to select a list of 20 such services from the Service Directory included in the packed of information distributed as part of the orientation process. Each resident received this Directory, along with other information describing the Senior Center and its programs. During the personal interview, the resident was handed the list of services, and asked the following questions about each service:

> *Have you ever heard of this kind of service?*
>
> *How familiar are you with such services: 0 = not at all, 1 = somewhat, 2 = fairly, 3 = quite, and 4 = very familiar?*
>
> *Do you know where you could refer someone who wanted information about such services?*

The average number of services the residents had ever heard of was 14.4 (SD 3.2) out of the 20 presented; the range was 7 for one resident to 19 for one resident.

Having heard of a program is, of course, minimal familiarity. When we examine the self-rated scores for familiarity, it is clear that most residents do not feel very familiar with most of the services available. Table 4 indicates the average (mean) rating of familiarity for the services, grouped according to degree of felt familiarity.

**TABLE 4**

**RESIDENT FAMILIARITY WITH COMMUNITY SERVICES TO SUPPORT ELDER HEALTH CARE**

(Self ratings, where 0=not at all, 1 = somewhat, 2 = fairly, 3 = quite, 4 = very)

| FAIRLY (2) TO QUITE (3) FAMILIAR | MEAN SCORE | % QUITE OR VERY | (N) |
|---|---|---|---|
| Nursing homes | 2.7 | 63.7 | (7) |
| Home care and meals | 2.5 | 27.3 | (3) |
| Support groups | 2.4 | 45.5 | (5) |
| Alzheimer's Disease information, aid | 2.3 | 36.4 | (4) |
| Senior centers | 2.1 | 18.2 | (2) |
| SOMEWHAT (1) TO FAIRLY (2) FAMILIAR | | | |
| Adult Day Care | 1.8 | 9.1 | (1) |
| Adult education | 1.3 | -0- | (0) |
| Transportation for older adults | 1.3 | 9.1 | (1) |
| Volunteer opportunities for older adults | 1.2 | -0- | (0) |
| Financial assistance for older adults | 1.0 | 9.1 | (1) |
| NOT AT ALL (0) TO SOMEWHAT (1) FAMILIAR | | | |
| Counseling and case management | .9 | 9.1 | (1) |
| Sick room supplies on loan for home use | .9 | 9.1 | (1) |
| Housing for older adults (not nursing homes) | .9 | -0- | (0) |
| Home delivery of books | .9 | -0- | (0) |
| Elder abuse programs | .7 | -0- | (0) |
| Chore services | .6 | 9.1 | (0) |
| Legal counsel for elders | .6 | -0- | (0) |
| Employment programs for seniors | .5 | -0- | (0) |
| Friendly visitors | .3 | -0- | (0) |
| Dental care for the homebound | .2 | -0- | (0) |

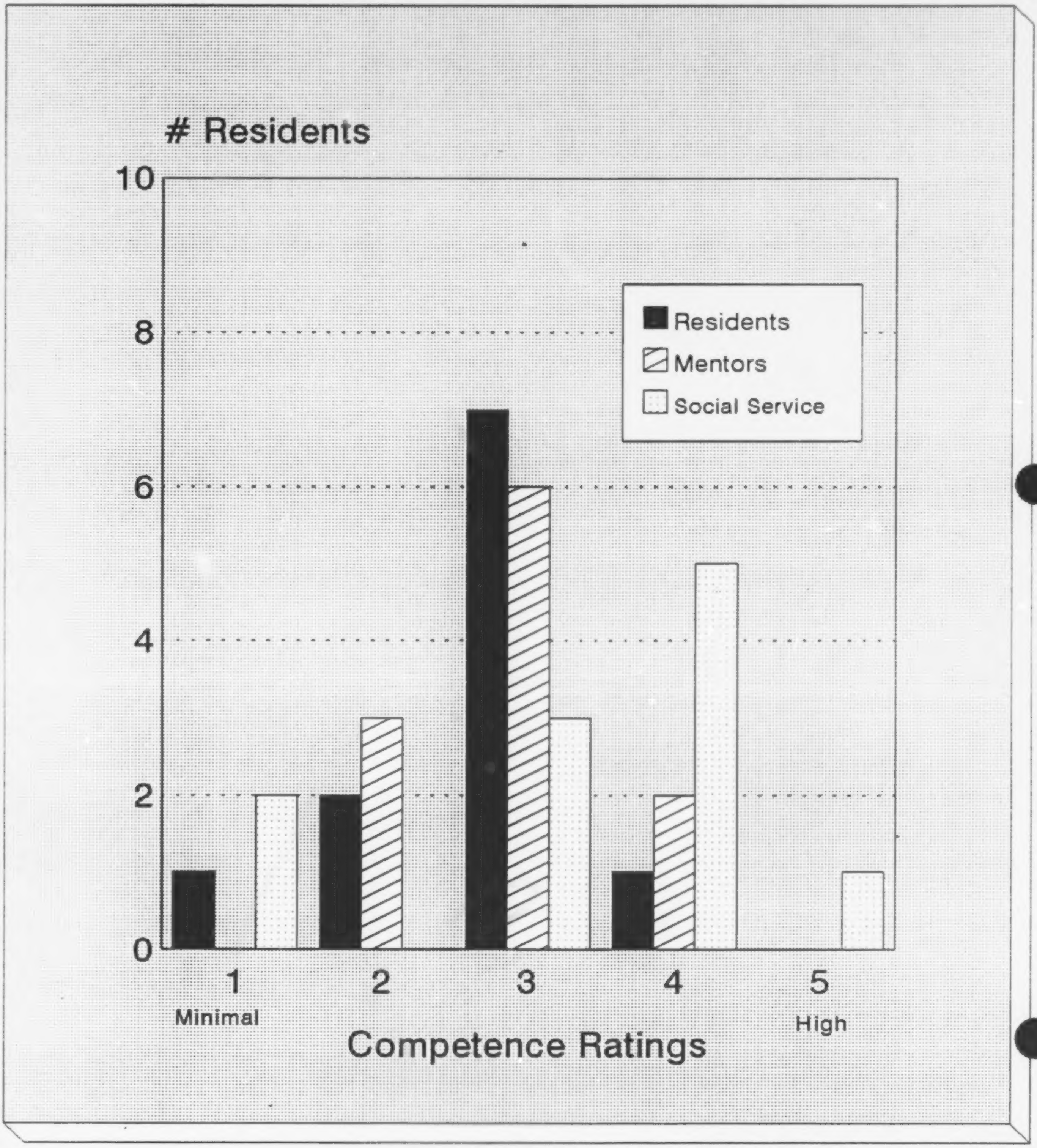
If we take the self ratings of "quite" (3) or "very" (4) as evidence of desirable levels to work effectively with other health care professionals in planning treatment programs, the challenge is clear. About half of the residents regard themselves as comfortably familiar with only two of the services: nursing homes (63.7% rate themselves as quite or very familiar with such services) and support groups (45.5%). This is perhaps not surprising, since the substantial focus of the geriatric rotation outside the NSSC involves nursing home experiences, and one of the major foci at the NSSC is some of the highly-effective support groups. It is, however, notable that most of the residents regard themselves as only "fairly" familiar with the most familiar programs. Residents feel they are minimally familiar with most of the services. For the majority of services, no or only one resident indicated they were quite or very familiar with the service.

When asked if they would know how to find out about such services, the residents offered varied strategies. Many would ask a hospital or senior center social worker or nurse; some had ideas about more direct contacts (such as looking in the Directory or calling someone they had dealt with previously), and some had no ideas.

The second way of estimating competence was to have the residents rate themselves on familiarity with community support services which could support health care for older patients. The self ratings on this dimension were notably lower than on the other dimensions, perhaps because these ratings followed the review of community services. Residents rated themselves an average of 2.7 on current competence, 1.6 before the rotation, and hoped to reach 4.1 within five years. The senior center professionals rated the residents as 3.3 average competence, and the mentor physicians gave an average rating of 3.1.

## Figure 7

Familiarity With Community Services
Current Competence of Geriatric Residents Rated by Residents, Mentor Physicians and Social Service Professionals



As part of the orientation to the NSSC, each resident was given a packet of materials describing the Senior Center and the activities going on there, the Directory of community services, and information about the program. During the interview, each resident was asked *"Did you read the material in the resource packet from the NSCC?"* Only two residents said they read all of it; seven said they read "some of it", and two indicated they had not looked at the materials. This suggests that some more emphatic method must be used to bring these potentially-useful materials to their attention.

Overall, it is safe to conclude that this is an area of marked deficiency. It is also an area in which the NSSC component has substantial potential to increase the awareness of important services to help maintain older adults in the community.

## 4.5 Question #5: *How do these professionals view geriatric practice?*

### 4.5.1 Findings

**Most of these professionals are positive about treating older persons and are willing to do so. Geriatric practice is seen as intellectually challenging and complex. Most are very positive about working with social workers to provide good care for older patients. The physicians perceive varied difficulties with geriatric practice, largely related to inadequate compensation for time-intensive appropriate care. Most prefer to work with adults of all ages, in part to satisfy therapeutic ambitions. There is substantial ambivalence about the desirability and feasibility of encouraging geriatric specialization. Women residents seem to be responding to geriatric practice somewhat differently from the men residents.**

4.5.2 Evidence The summary statement above reflects measures used to assess the ways that the medical residents and mentor physicians, in particular, feel about using their medical skills in the service of older persons. In part, such questions recognize the clear and obvious need for increased resources available to deal with an aging population. More specifically, the strength of any program designed to help younger physicians treat older patient effectively probably depends significantly on the modeling of the senior physicians. The NSSC program is explicitly designed to provide close collaboration between the resident physician and the mentor; thus, it seemed desirable to assess the attitudes of both groups.

The data to be discussed below includes responses to self-report questions on the Personal Attitudes Questionnaire (a 5-point rating scale) and responses to questions posed in the personal interviews.

### (1) Most characterize geriatric practice as complex, challenging, and inevitable.

Working with older patients is not regarded as much of a choice by these physicians specializing in internal medicine. This theme was prevalent throughout the interviews with residents and mentors. They recognize that the population is aging, and that older persons use more medical care. Thus, regardless of how they feel about that fact, most of the physicians interviewed for this project feel that older patients are an important part of their practice.

Given that reality, most also describe special issues that emerge. Most, but not all, describe elderly patients as different and requiring some special knowledge and intervention approaches. The "differentness" is described most often in terms of **complexity**. Older patients typically have multiple, complex medical problems; medical problems are often intertwined with psychosocial problems, and treatments may have to be altered because of non-medical considerations; elders and their families are often dealing with complex life-and-death decisions. In part because of the complexity of the issues, and in part because the elderly themselves have slowed down, virtually all of the physicians describe geriatric practice as more **time consuming.**

The complexity is more often regarded as a **challenge** than a frustration. As seen in Table 5, most of the physicians (and all of the senior center professionals) agreed that "*Geriatric medicine is an intellectually challenging specialty*"; they disagreed with the statement "*It's frustrating to treat old people because they have so many problems.*"

**TABLE 5**

**ATTITUDES TOWARD GERIATRIC PRACTICE**

**(Average agreement with statement, where 1 = Strongly Disagree, 5 = Strongly Agree)**

| Statement | Residents | Mentors | NSSC |
|---|---|---|---|
| I enjoy working with older patients. | 4.5 | 4.8 | 4.9 |
| Geriatric medicine is an intellectually challenging specialty. | 4.3 | 4.2 | 4.8 |
| It's frustrating to treat older patients because they have so many problems. | 2.3 | 2.2 | 2.0 |
| Treating older patients means you seldom get the satisfaction of really helping someone get well. | 1.7 | 1.4 | 1.6 |
| Even if there are a lot of old people who need medical care, I hope that someone else will care for them. | 1.5 | 1.9 | 1.8 |
| My interest in geriatrics [gerontology] has decreased. | 1.9 | 1.1 | 1.6 |
| I [plan to] collaborate with social workers [physicians] in treating older people. | 4.8 | 4.4 | 4.6 |
| I consider myself a [intend to] specialist in geriatrics. | 1.9 | 4.2 | 4.2 |

**Note:** Words in [brackets] indicate alternate forms that were used to make the statements appropriate for the residents, mentors, or North Shore Senior Center professionals.

### (2) The rewards of treating older persons are largely intrinsic, keeping valued elders functioning, enjoying their appreciation of good care, and feeling competent in dealing with very complex challenges. Some value the opportunities to work with patients in a more holistic way.

As indicated from the self-reports in Table 5, most of the professionals in this study said they enjoy working with older patients. In the interviews, they identified a variety of attractions in such a practice.

> "There is a lot you can do for a geriatric patient, just like any other patient. The rewards are a little different, though not a lot. Often you can do more in a supportive way; there are things you can do that aren't strictly medical. Part of the rewards are in their appreciation of what you can do, medically and psychologically...What I love is that you get people who have lived a full life, and are full of knowledge. I learn a lot. It's fun to keep them living and traveling to Antarctica." (Resident)

"I like it. I've considered going into it as a specialty. I'm much more tolerant of old people who are not my parents. Old people are great--they have a lot to offer. And when a 95 year old gets acutely ill, it's not as drastic as when a 36-year-old is acute; it's a more manageable lifestyle for the doctor. If an old person is admitted to ER, you expect it; you can see them tomorrow. You'd have to run right over with a 35-year-old, because you don't expect it." (Resident)

"They seem like a nicer population, just nice people. They're more appreciative of the time you spend; friendlier and more compliant." (Resident)

"I like geriatric practice. You do things more slowly. It takes longer to figure out what is going on. It's a part of internal medicine that is different. You book 45 minutes for a physical. The slower pace is enjoyable. I have no problem with any of it. [No problem?] None at all." (Resident)

"I have learned from the older patients that simple inputs to a patient problem can result in big rewards; for example, treating incontinence can markedly improve the quality of life. You can do a lot to improve the quality of life, without expensive or tortuous tests." (Resident)

"With the elderly, it can be depressing because you know the course their problem will take. The advantage is you see what they are going through and you can help them. If you learn to take care of them you get a reward from that. I can see the difference; my mentor physicians know more about the problems of the elderly, and could get to the problem right away. Their expertise made a difference." (Resident)

"There are a lot of difficult issues to deal with at the end of life, big picture things like prolonging life. My idea is to address issues when they are healthier, so everyone is on the same wave length. The internist is the one you should have rapport with and deal with the big picture issues. One attraction is that you can make an impact in helping people keep their independence or manage chronic problems. You can keep them functioning in their 70s, 80s, 90s. As a whole, the older patient is more appreciative, even when they hear there's nothing more to be done. They feel is I'm doing my best, they will too. They really cope with a lot, well." (Resident)

"All in all, I enjoy it, even those who are bedridden or cognitively impaired. There are challenges to making their lives better; it forces you think about the big picture... I like the way I am able to practice at our facility. There are lots of frail elderly who don't do well with outpatient assessment, but in-hospital assessment is too expensive. I recognize now they can be treated well, in a small infirmary. I admit them and watch them get better. I really like the longitudinal followthrough." (Mentor)

> "The attractions include the tremendous need, which makes it worthwhile. There are tremendous opportunities, because so little has been done, to have a full service operation that provides exemplary full-service care. That's what most doctors would want to do, but after medical school they get more and more reductionist. Geriatrics offers a way out of the bind; you can be a full-service doc, and still have all the expertise available. It is, finally, good for a lot of personal gratification. The patients and their families are grateful and you see are doing something intrinsically worthwhile." (Mentor)

> "There's a lot of pathology--you know you'll find something makes you feel worthwhile. It's a challenge to keep them going. With a 30-year-old, you aren't likely to find anything interesting on a physical; that's not true for older patients. Maybe there's another thing. When you're dealing with someone 75 you can take more risks, and they are willing to take more. The pressure for saving life is different. Anything you do is a plus if you keep them going." (Mentor)

> "Rewards are few because few survive. I define rewards as short term: I managed to get two years more of good life. I have high respect for the elderly; I care for them as I'd care for my own parents." (Mentor)

> "The problems are complex, so geriatric medicine is both difficult and problematic. It's satisfying when I can handle it well, even though it's mentally and emotionally taxing. From a practice standpoint, they're the ones who need the most medical help; there's never a dearth of patients. They're always there." (Mentor)

> "There are a lot of personal satisfactions in caring for older people. I like older people, delving into their histories; they are like my grandparents. Their problems are complex, and that's the core of internal medicine--to deal with the complexity and not loose sight of the whole." (Mentor)

### (3) The major problems in geriatric practice are status and compensation. Other issues include accepting care (rather than cure) as a therapeutic goal, and managing the substantial complexity of medical care, particularly for patients who are confused.

During the personal interviews, respondents were asked to describe how they felt about geriatric practice. **Six of the nine mentor physicians identified Medicare reimbursement policies as a specific problem in recruitment, retention, and satisfaction**

**with geriatric practice**. These and other issues are important to address insofar as these affect recruitment and retention of health care professionals to work with elders.

> "The problems come basically with the **image**, which makes it difficult to carry out what we want to do. Geriatrics is not sexy, high-tech, or glamorous. It's perceived as working in God's anteroom, where you don't affect the outcome. They are wrong, but it filters down. It makes it difficult to get the best and the brightest into the field. Low reimbursement is a problem, though that impacts more in recruitment than our own personal feelings. Some of the problem with lower pay is ego, but it also affects us in dealing with the hospital administrators. A doc can make lots of money on bypass surgery, but not with older patients with multiple psychosocial problems. A heart surgeon can get 80% of $5,000, but I can charge maybe $90. for a new patient evaluation, and Medicare only covers 60-80% of that. So the managers of the group practice think I'm a pretty low risk." (Mentor)
>
> "Medicare is the biggest problem. The remuneration is about two/thirds of other care, and the care takes longer." "The biggest problem is money for a private practice. It would be difficult to spend the time needed for quality care with the current fee structure. It takes internal medicine to a different plane; it's already known for taking more time. With a geriatric patient you can take that to the extreme--and see only three or four folks a day. But you can't pay for your house and your food that way." "You have to allow half an hour per patient, and you need support services; this is too expensive for most private practice, especially when reimbursements are lower." (Mentors)
>
> "The elderly get short changed in being able to sustain their quality of life. The government does it. Look at Medicare. Social Security does not provide good care; it's very costly and there just isn't enough money. Caring for elders can be a potential burnout." (Mentor)
>
> "Geriatric patients have more complicated problems, and we are less able to really cure them. We can help the patient work through it, but that requires more of the psychosocial skills." (Mentor)
>
> "You can do a lot of things and have minor impact. Sometimes there isn't a lot of sense of accomplishment. If you keep a woman alive after a stroke and she recovers to be demented, what's the point?" (Mentor)
>
> "Sometimes the patients are childlike, demanding, boring, repetitive, rambling. It takes a long time to deal with them. You have to have a lot of patience." (Mentor)

> "All patients can be demanding, but the geriatric patient and the families can be very demanding. You have to talk to so many people. Polypharmacy is a problem, because the drugs all interact. It's hard so sort out the psychosocial and medical when you are dealing with something like depression, cognitive impairments, or drug reactions. And communication is more difficult; it's hard to know how to deal with them." (Resident)

> "I get frustrated with the older patients not understanding me. It's hard in the nursing home, with the families and placements and the very complex problems. There are still areas I'm uncomfortable with, like tube feedings, neglected patients in the homes, families unaware of the medical problems, code status, when is the best time to talk to patients, what to do with patients who smoke and have emphysema." (Resident)

(4) **Virtually all of the physicians feel very positive about collaborating with social workers, in geriatric education at this level and in geriatric practice. The senior center professionals are very positive about strengthening collaborative bonds in both education and practice.**

Virtually all of the residents and most of the mentors agreed with the self-report statement that they do now, or intend to, collaborate with social workers in treating older people. This rating reflects their beliefs that the social workers are valuable partners on the health care team. During the personal interview, **mentors** were asked: *"A distinctive feature of this program involves close collaboration with social workers. How do you feel about this emphasis as a part of the medical education at this level?"* Many of the mentors discussed ways in which the residents need to learn to collaborate with other professionals.

> "It's a good venue in which to employ the collaboration. It's something the residents should have. In terms of the stated objectives, we really rely on them. They supplied much of the holistic element." (Mentor)

> "Tremendous! Within the geriatric rotation we should have residents spend a day a week with the social worker in the hospital, too. I know most doctors don't know how to discharge patients, for example. We send patients home very early. We should have the residents fill out all those discharge plan forms, so they'd learn what's available, who can pay for it, and how to use the social worker. It would be an excellent learning experience. It would be invaluable." (Mentor)

> "It's central. Most of the residents will not be part of a geriatric team. They'll be in a practice, and must appreciate what the social worker can bring to patient care." (Mentor)
>
> "It should be done earlier. By this time a lot of patterns are set. Geriatrics must be a team approach, and the sooner the doctor realizes this the better off they are." (Mentor)
>
> "It's good, but the social workers have to realize they must come with something to offer. They have to be more concrete and focused. Then they can be more effective and the residents will be more ready to learn. It's hard to break out of the medical mode. [That a doctor can only learn from another doctor?] Yes, that's a problem. [So what did the social workers do that was good?] They provide insights, especially about the family dynamics that you don't think about. It lights up the resident. So the more of that they do, the more effective it will be. They need to be more active." (Mentor)

The **residents** were asked a similar question during their personal interview: *"A distinctive feature of this program involves close collaboration with social workers. How do you feel about this collaboration in your future medical practice?"* They were equally positive.

> "Great! They're wonderful! You can only do so much and then they take over. I've worked closely with some at the nursing home. The home visit was so good, to see how they cope. And the women who ran the groups. They offered themselves to the residents and talked to us. They were very good in giving informal feedback and that's how I learn best." (Resident)
>
> "It's really essential. There are more issues to health care than medications. You have to see about the environment. You need help from social workers." (Resident)
>
> "It's going to be an important part. They have their expertise, and I have mine. I realize how much they can do to improve the total situation." (Resident)
>
> "They're invaluable. They know so many things. They're a real resource. They work real hard. In this program I really learned from the social workers." (Resident)
>
> "It's very important. Doctors and social workers need to work closely together. Social workers need to tell doctors what we need to know and what they do. They have to toot their horn and let doctors know what they do." (Resident)

The **NSSC professionals** were asked the same question as the mentor physicians about how they felt about the collaboration between social workers and physicians at the residency level of medical education. Perhaps not surprisingly, they expressed very positive thoughts about the ways the program could benefit all involved.

> "I think it's very important. I think that residents more and more know, as they send people home sicker, there has to be community involvement with the visiting nurse and home health care people. They need to know that the social worker coordinates these services. I also think that the social worker can help them deal with feelings that the patient and the family have. We can help them understand part of getting well is learning how to cope with the disease." (Social worker)

> "I think it's very good. It's good for social workers to feel part of a collaborative team with doctors. And I assume that doctors learn something from it. There are a lot of issues in geriatrics that can't be addressed unless the social workers and the doctors work together. I see it most clearly when it doesn't work. Right now, I have an elder abuse case in which I'm having a hard time getting the doctor to collaborate with me. So it's really good to teach the residents early to do this." (Social worker)

> "It's essential. I think it's giving us a way to impact on the way physicians view patients in the home situation. It makes their experience more diverse. They don't have this opportunity in medical school to learn what other disciplines can do." (Social worker)

> "It's very important that we be seen as part of a team. I think it may make life easier for the doctors if they don't have to do it all and can refer to community resources. It also helps the social worker see that the doctor can't address all the social issues; we can help the doctor." (Social worker)

> "I think it's extremely important. Social workers, especially those in hospital settings, get a bad rap; they are low in status and not used as much as they could be. When the doctors know more about what we do they are more comfortable in referring to us. It's not their job, but families need to use social workers and social services. Doctors hold much more authority and families listen to doctors." (Social worker)

> "The physician needs to give up the attitude of 'I can't handle it so I'll call a social service agency.' Time is so important. The physician should spend some time up front to assess the larger problems, not just the patient but the whole person. They should call us in earlier, so we can help plan, not just respond to an emergency." (Social worker)

**(5) Residents say they enjoy treating older people but do not intend to specialize in geriatric medicine. This stance reflects a more general ambivalence about the need or desirability of making geriatric practice a distinct specialization. Most seem to endorse the integration of geriatric and gerontological knowledge into existing medical domains, and most prefer an age-integrated practice.**

The issue of where geriatrics fits into the organization of academic and practice medicine was not a central focus of this research. However, because the program under review is a component of the rotation in geriatric medicine, the issue emerged in various ways. Because the issue seemed to inform responses to several questions, I began asking more systematically about these issues after the first few interviews.

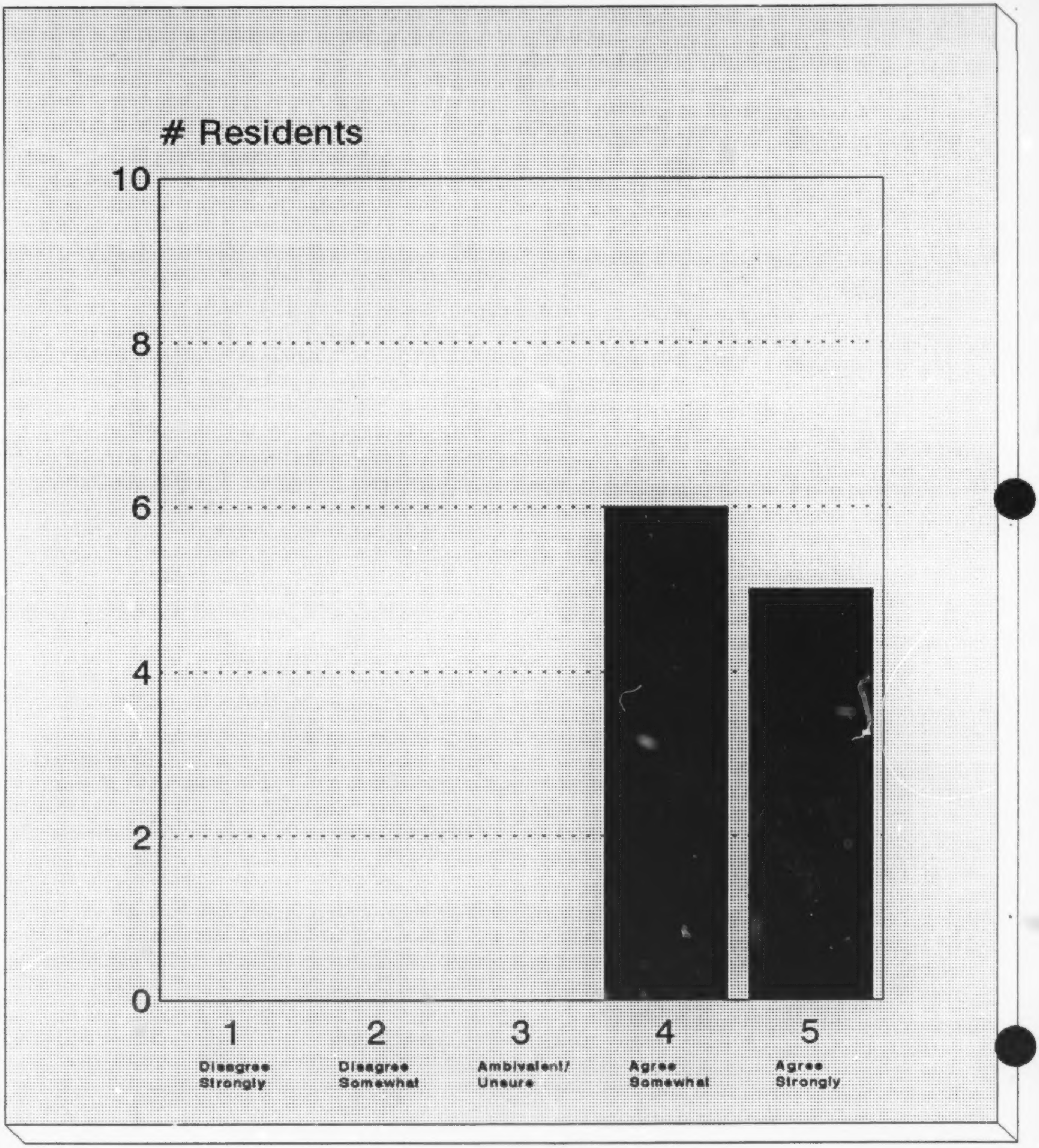
As evident from the responses summarized earlier in this report, the physicians in this sample feel positively about older persons generally and expect to spent substantial time treating them. However, the medical residents **disagree** with the statement *"I intend to specialize in geriatric medicine."* On the self-report questionnaire, six of the eleven residents disagreed strongly, one disagreed somewhat, three were ambivalent or unsure, and only one agreed somewhat that they intended to specialize in geriatric medicine; see Figure 8.

The reluctance of the residents to say they would specialize might be taken as affirming the bad news: physicians don't want to treat the elderly. However, the rest of the interviews, and their other responses to the questions indicate a more complex relationship between attitudes toward older people and intentions to care for them.

The useful interpretation of the specialization must be anchored in the larger context of what geriatric specialization currently conveys. Most of the mentor physicians and the residents indicated that geriatric medicine is currently defined in terms of caring for the

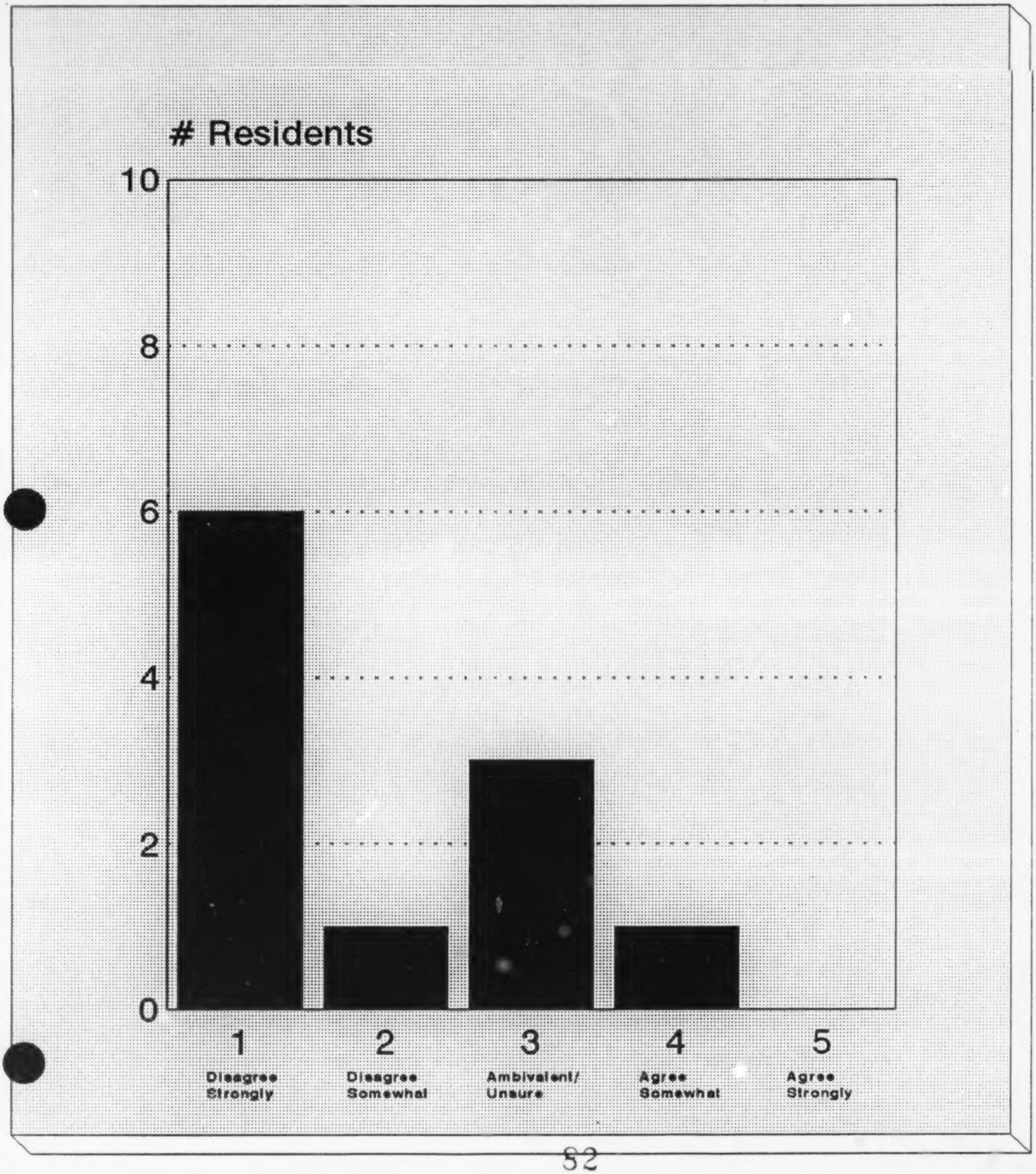
Figure 8

"I enjoy working with older patients"
Responses of 11 Medical Residents Completing Geriatric Rotation



## Figure 9

"I intend to specialize in Geriatric Medicine"
Responses of 11 Medical Residents Completing Geriatric Rotation



diseases and ailments of the very old; pragmatically, they see this as involving special expertise in nursing home placement and care, dementia, incontinence and terminal care. As thus defined, it may, indeed, be seen as "serving in God's anteroom", as one mentor so aptly expressed it.

Obviously, this definition of geriatric medicine is not really what the professionals at the senior center have in mind: they think of "geriatric medicine" as focused on how to keep the vast majority of older individuals functioning independently as long as possible, in their familiar settings if possible. The medical practice of serving the "well elderly" is, apparently, currently assigned to internal medicine or family medicine practitioners. Hence, some of the ambiguity and ambivalence about whether one declares a specialty in geriatric practice. As it is currently defined, it seems like a limited specialty.

The issues were articulated clearly by one of the mentor physicians who is Board Certified in Geriatric Medicine but who believes that geriatrics should be retained as an **academic specialty** informing all physicians about the specialized body of knowledge. However, **geriatric practice** should be integrated within internal and family medicine. The assumption guiding medical training should be that all physicians offering primary care will work with many elderly. This perspective seems to reflect the prevailing sentiment among most of the mentors, as revealed in comments about geriatric practice and who should take a rotation in geriatrics.

> "I don't see any reason for geriatrics except in academic medicine. In practice you need to be aware of the special needs. Internal medicine physicians should care for the whole life cycle; otherwise you lose the perspective of whole health and longitudinal care... I enjoy taking care of the elderly, but I enjoy the break of seeing a 35-year-old. I see about 65% elderly in my private practice. I feel close to the elderly. They are usually very appreciative and in need of help." (Mentor)

> "I think to be an internist you have to be a geriatrician; I don't see the difference between internal medicine and geriatrics. But by making it Board Certified, it defeats the trend to get people into internal medicine. I wouldn't be exclusively a geriatrician. I feel it's primary care. The balance in my practice gives me appreciation for all groups. Our practice is run like a family practice, and I realize how much it enhances everyone when young and old are near. For me, I avoid burnout and I can be more realistic about what's possible in care for elders. Is it reasonable for the 55-year-old children to care for the elder? They are **all** my patients. I have four generations in some families; I like that." (Mentor)

> "Everybody in internal medicine should study geriatrics. The internist is the generalist; he's at the head of the ship and directs care. He calls in the specialist." (Mentor)

> "I think one should be a generalist in medicine; all geriatricians should care for younger patients, too. Geriatrics is a subfield of internal medicine; we can understand old age better by understanding middle age and younger years. Older people are fascinating. We need to teach **all** students that every patient encounter involves story telling; that's how you get a good history. Elders have long fascinating stories that five-year olds don't have. And, as we know, the older group is the fastest-growing group; we have many potential problems, including interclass and interage problems. We need those who understanding aging to bridge these divisive splits." (Mentor)

> "I don't think there should be specialists who call themselves geriatricians. The way it is now, they claim that when a person becomes old and is really sick, then the general practitioner should refer the patient to them. But I am an internal medicine specialist, and I care for my patients over the whole life course. I have two objections. One, I don't believe that a new specialist can provide better care than I can, having known this person over a long period of time; we have a relationship of trust, and I know the whole family. Second, when my patients are younger they don't need much care. Why should I lose my patients as soon as they begin needing a lot of care?" (Mentor)

The **medical residents** had similar perspectives about the desirability of having an age-integrated medical practice, in part to satisfy their therapeutic ambitions.

> "Geriatrics is not something I want to do on a full-time basis. I intend to have an age mix. The vitality of young ideas and the health issues are part of it. You see more benefit with younger patients than with patients who are very old and chronically ill, when you are just maintaining them." (Resident)

> "I enjoy geriatric medicine and I'd consider being a gerontologist, but I need a more diverse population. I want to be able to diagnose and treat a lot of the things I've learned about but that occur earlier in life. I'd like a few cures." (Resident)

> "I appreciate geriatric medicine a lot more now. I thought it didn't need to be taught, but now I realize there are specific problems that can be handled by specialists. I appreciate their training in these problems. Dementias particularly are very difficult to deal with." (Resident)
>
> "I enjoy geriatric medicine. It's important and everyone should excel in it. Even if you only have 30% of your practice who are older, you'll see them 50% of the time. I'm with a group practice and if I give older patients the best care I can, I'll get more than my share. Including more than just the medical is important in that." (Resident)
>
> "I really enjoy geriatric medicine, and if I didn't have a drive toward oncology I'd do geriatrics. However, one of the detractions of geriatrics is dealing with one age group; I see myself as dealing with a wide age range." (Resident)
>
> "I won't avoid the elderly, but I don't want to specialize in them only." (Resident)

Mentors and residents were asked *Who do you think should take a rotation in geriatric medicine? What makes that reasonable?"* Some of the physicians in both groups recommended that **all physicians** should receive training in geriatric medicine, given the realities of an aging population. Most of the respondents, however, recognized that some physicians would have so little patient contact, or be so removed from dealing with older adults that geriatric training would be unnecessary. The majority of both residents and mentors said that **all internists and most specialists** should have training in geriatric medicine in order to deal effectively with the emerging realities of practice. One mentor and one resident suggested that a rotation would be appropriate primarily for those who intended to specialize in geriatric teaching or practice; as the resident explained:

> "The only person who should take a rotation in geriatric medicine is someone who is interested in going into a geriatric fellowship. There should be a specialty of geriatric medicine for those who want to take care of the nursing home population or who enjoy dealing with older patients only. But general internal medicine has changed enough to make it unnecessary. In the hospital most of the people we see are older. The people with the most serious problems are old. So after three years, I've seen a lot anyway, so you don't need a special rotation." (Resident)

(6) **The women medical residents seem more willing than are the men to include the broader psychosocial perspectives into their practice.**

This research was not designed to explore possible gender differences in the ways that physicians respond to medical education and structure their own careers. There is substantial evidence that gender is an important variable affecting the ways adult lives evolve generally, even though there is little agreement about the sources of such differences (Huyck, 1991). There is also growing interest in how the increasing numbers and proportions of women entering medicine may affect the profession and available care.

Perhaps by good fortune, the group of residents participating in this rotation included six men and five women; based on comments from some of the respondents and my own sense of patterns emerging, I decided to do more systematic analyses for possible gender differences, recognizing that the very small numbers involved makes it difficult to use the findings as anything but provocative. For these analyses, I took all the measures on the residents and performed statistical T-Tests on the two groups, to see what differences emerged between the groups of men and women. (In the summary below, the level of statistical significance is given; none are reported if they are above $p<.10$, usually considered evidence of a "trend"; and most are less than the standard $p <.05$.)

Overall, the pattern of differences suggest that the women are more open and enthusiastic about the NSSC component; identify more psychosocial and caregiver issues in the hypothetical patient situation and are evaluated as more competent in psychosocial issues by the mentor physicians; and are somewhat less comfortable with the unstructured learning situations.

## Gender-linked Patterns of Response

- Women agree more strongly than men that the NSSC portion of the rotation should be expanded ($p < .00$); and they disagree more strongly that internists have too many medical things to learn to bother about becoming familiar with community resources and family functioning ($p < .08$).

- Women were more likely than men to respond to the hypothetical patient description of an elderly women and her daughter by saying that the bruises should be investigated for possible elder abuse ($p < .02$); that the home should be checked for social isolation ($p < .04$); and that she would give the daughter permission to meet her own needs ($p < .10$). Women were also more likely to identify a hematoma as a possibility in this case ($p < .00$).

- Mentor physicians rated the women residents as showing more understanding of the psychosocial issues in health and illness among older adults (4.0 vs 3.4, $p < .03$).

- Women anticipated developing more sensitivity to family caregiver concerns in the next five years than did the men (5.0 vs 4.2, $p < .00$).

- Compared to the men residents, the women were less likely to describe one of the less-structured experiences as contributing to learning about psychosocial issues ($p < .04$), and somewhat more likely to indicate that discomfort with unstructured situations limited learning about psychosocial issues ($p < .10$). Women were also somewhat more likely to say that goal unclarity limited learning ($p < .10$).

Possible gender differences should be explored further, since these results suggest differences which are congruent with other evidence about the ways that women and men are socialized and respond somewhat differently to similar situations.

## 5. DISCUSSION

### 5.1 Relevance of Research to the Agency

The evaluation of the North Shore Senior Center component of the geriatric rotation at Evanston Hospital has affirmed the initial conception. The participants are very positive about the idea, and they recognize that the first year of the program has been a successful learning experience in many ways. The evaluation is clearly positive. The residents feel that many of the programs have contributed to their understanding about the complexities of providing excellent health care to the broad range of non-hospitalized and non-institutionalized older adults. The mentors feel that the residents have benefitted, and often that they have benefitted as well. The social workers and nurse at NSSC are enthusiastic about entering into this more collegial teaching relationship with the physicians.

The evaluation also has identified clear options for modifying the program to make it more responsive to the goals established. The 31 professionals interviewed for this research provided many specific suggestions for enhancing the basic program; these lists will be one basis for discussions between the EH and NSSC professionals about how to revise the program. Presumably, the lists will also inspire additional suggestions.

This report provides a kind of "baseline data" for future evaluations. The strengths and limitations of the program overall, and specific components of the program, are available to compare with future years of the program. In addition, the competence of this group of residents can be compared to assessments of future residents, though such comparisons must obviously made with great caution since the method of assessment is unlikely to be the same. Attitudes toward geriatric practice can be compared for successive groups of physicians.

## 5.2 Limitations

The primary limitation of this as evaluation research is the post-hoc design: the goals were defined explicitly only as part of the evaluation process, and there was no assessment of the competence of the residents when they entered the geriatric rotation. It is impossible to gauge the impact of a set of experiences without measures before and after the experience. It is also highly desirable to compare the competence of those who have the experience (the rotation) with those who do not, but who may turn out to have similar competence levels.

We must also keep in mind that the program changed over the course of the year, so we are, in essence, "capturing" different experiences and summing them as if they reflect some more stable set of experiences. For example, in response to early criticisms from the residents that the Wellness Clinic was too unstructured, the physicians introduced a new, standardized routine of asking each client whether she or he had heard of various preventive health practices, and whether she or he engaged in those practices. The problem of program change during the process of evaluation is largely one of research "purity": it is difficult to describe clearly just what has been evaluated, and to sum the descriptions and assessments of that changing reality. However, such change is a reality of any dynamic program; it seems preferable to recognize that the program will change over time; evaluations still need to be done. The fact of change does suggest, however, that the evaluation process should be ongoing, so that, at the least, the evaluator can describe the changes at the time and check for responses to such changes.

While the response rate is exemplary (100%), the absolute numbers are small. We must be cautious about generalizing from 9 mentor physicians, 11 residents, 10 social service workers and one nurse. All were articulate and thoughtful, and they have contributed many careful observations and recommendations. It is most appropriate to regard these respondents as "expert informants" on complex human systems. Their voices are important, but we must hear other voices, too.

## 6. IMPLICATIONS

### 6.1 Educating Physicians in Geriatric Medicine

The research strongly supports the use of a senior center as an appropriate setting for geriatric education. A multipurpose senior center offers excellent opportunities to see how various structured programs can support healthy vital functioning among older adults and their family members, and how community support services can help maintain even impaired elderly in a home setting. The opportunity to work collegially with social workers in a setting that is less hierarchic than most hospitals provides valuable experiences in effective team work.

One still-unresolved issue revolves around the appropriate point for such educational experiences. My sense from the respondents is that consideration of the psychosocial and broader context of health care must be an expansion from a secure base of medical expertise. The student who was most negative about the NSSC experience had a similar orientation in medical school, and he was very concerned about being inadequately trained in basic medicine. Several of the physicians indicated that medical school must continue to focus primarily on mastery of basic medicine. From that basis, the physician can more confidently and competently function within her or his expertise on a health care team.

Another issue revolves around the appropriate degree of structure in the education of physicians into dealing with older patients. Most of medical education is didactic, requiring memorization of great masses of facts, names, processes, etc. On the other hand, actual practice or research requires the kind of flexible, creative thinking that marks any of the professions where science and art merge; knowledge is inexact and part of "knowing" may be implicit and undocumentable. Social workers are educated less by memorization and more by developing clinical sensitivity to the individual definitions of experience. Immersion in the senior center provides an opportunity for the residents to develop those more clinical ways of knowing, among other things. However, the different standard ways of instructing and learning contribute somewhat to the tension when physicians are brought in to learn from social workers.

## 6.2 Recruiting and Retaining Physicians for Geriatric Practice

The message from this group is clear: physicians are quite willing to learn about geriatric medicine and to treat older people but they do not wish to be limited to geriatric practice as it is currently defined. There seem to be two possibilities, at least. One is to re-define geriatric medicine, to take it beyond the maladies associated with the "Fourth Age" of decline and termination to include all the strategies needed to maintain reasonable functioning during the "Third Age." This strategy is not likely to succeed, given the apparent realities that internal and family medicine practices already include a dominant focus on providing care that will preserve healthy functioning during the adult years. Thus, it seems better to integrate information about geriatric medicine into all existing educational structures, and to prepare physicians to practice appropriately with patients who cover a wide range of chronological ages. While pediatrics seems to "make sense" as a medical specialty, it is not clear that geriatrics does.

It is also clear that there must be a major effort to address the issues of adequate compensation for providing more time-intensive geriatric care. This could be accomplished via several mechanisms, such as revising Medicare reimbursement policies even more, moving to a national health system and compensating all physicians more evenly, etc.; the evaluation of such alternatives is beyond the charge of this analysis.

The participants in this study make it clear that there are many attractions to trying to understand the complex medical issues and to treating older people. Many are attracted by the intellectual challenge, and the excitement of this challenge and the sense of mastery to be derived from meeting those challenges must be conveyed to medical students. Physicians are also attracted by the desire to care for persons who are responsive and appreciative, and perhaps to provide the kind of care they would want for their own parents or grandparents. These compensations need to be made more clear to physicians.

It is also clear that part of the recruitment process requires well-organized programs in which the physicians feel they will become more effective. A strong, visible person who has adequate time to devote to developing and monitoring the geriatric portions of medical education is desirable.

### 6.3 Multi-disciplinary Team Building

Many of the professionals interviewed for this project acknowledged the need to utilize many perspectives in providing good health care for older persons. Thus, there seems to be broad agreement on this as a general goal. However, it is also clear that constructing and maintaining a multidisciplinary effort in which all professionals feel like equal partners in a complex process is very difficult. The difficult of crossing disciplinary boundaries is not news. What may be news is that this program offers one pattern for helping physicians and social service professionals become more comfortable learning from each other and benefitting from the expertise of each person on the team. Because this program is focused on the more psychosocial and support service aspects of health care, the physicians are in a setting where the skills and knowledge of the social service professionals are most evident. In such a setting it is more likely that all participants will develop mutual respect and trust.

Unfortunately, the realities of external social status (and compensation) affect the issues of providing medical education in a senior center. Physicians, as a group, have higher status and are much better compensated than are social service professionals. Social service workers tend to feel that they are lesser members of the team, which has the consequence of making them more reluctant to be assertive about what they know that the resident should note. Unfortunately, a few of the mentors (more than the residents) interpret such deference or status-consciousness as reflecting either ineptitude or excessive passivity. These potentially-troubling issues were much less problematic in this setting with this group than often reported in the larger literature; they were, however, evident.

## 6.4 Gender and Geriatrics

Gender includes the social and psychological consequences of biological sexual differentiation. There is substantial evidence that gender is one of the characteristics that influences the ways we perceive ourselves and others. I suggest that gender issues affect the patterns of recruitment and retention of physicians to provide care for elders, and gender issues impact on the likelihood of maintaining strong multi-disciplinary health care teams.

As described by the physicians in this report, good geriatric care involves careful attention to the non-medical issues, as well as the medical ones. In the larger social realm, sensitivity to complex psychosocial issues tends to be regarded as "feminine" and more congruent for women; while mastering complex technical procedures or recognizing abstract patterns or disease diagnosis tends to be regarded as more "masculine" and congruent with male gender socialization. Thus, one of the issues in attracting persons to work with older adults is the nature of the treatment; in later life, the emphasis is more on care -- women's specialty -- than cure.

Strong multi-disciplinary work teams require mutual respect and comparable status. This is more difficult to achieve when issues of gender status interact with professional status. In this group, those with the most status in the external world are the mentor physicians, all men. Those with lower social status, the social service professionals, are all women. It is widely recognized that, as a group men have more social status than do women. These group-level ostensible status differences can block the development of a truly-collegial team approach where all learn from each other.

The resident physicians are a mixed-gender group, and they provide some clue about the directions of future medical care. It is clear that women have been moving into previously male-dominated professions in substantial numbers. In 1988 in the U.S. 30% of family practice residents and 26% of internal medicine residents were women (Schaller, 1990). Of course, any shifts which may be linked to changes in the gender-composition of the medical profession are set in the larger context of substantial changes in the ways in which medical care is practiced. The general thrust seems to be toward more managed care, and toward some system which will require physicians to work more closely and collaboratively with other health care professionals.

The findings from this small group of residents are provocative, since they suggest that the movement of women into internal and family medicine may strengthen the kinds of care needed for the best elder health care. We can expect that the women and men physicians will work as partners to incorporate more of the psychosocial and health-team approaches into health care.

## 7. SPECIFIC RECOMMENDATIONS TO THE AGENCY

### 7.1 Build In an Evaluation Process

The need for systematic, ongoing evaluation of the collaborative program as it evolves is clear. The evaluation should continue to focus on the assessment of the improvements in functioning among the residents participating, and on assessments of the program as a whole and particular components.

### 7.2 Implement the Modifications Suggested

The participants in this evaluation review contributed a great many suggestions for modifying the program to enhance the learning experience; these have been summarized and discussed in Section 4 above. It is very important to engage in a systematic review of these suggestions, in order to assess the extent to which each of these possibilities seems desirable and feasible, and to establish some goals and timetables for implementing the desired changes. Having such a plan will facilitate the development of appropriate funding to cover the additional expenses of running and monitoring an excellent model program.

Planning must be carried out collaboratively with the medical training site, in this case Evanston Hospital. It will be impossible for either agency to be responsible for planning a successful program, since accommodations will be required in both agencies.

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## APPENDIX

Informed Consent Form for All Participants

Interview Protocol for Resident Physicians

Interview Protocol for Mentor Physicians

Interview Protocol for Senior Center Professionals

Biographical Sketch of the Author/Evaluator: M. Huyck

# EVALUATION OF NORTH SHORE SENIOR CENTER/ EVANSTON HOSPITAL MEDICAL EDUCATION PROGRAM

## Informed Consent

1. I volunteer to participate in a research study which is intended to assess the effectiveness of a pilot project to educate third- year Evanston Hospital Medical Residents in the observation and evaluation of older adults at the North Shore Senior Center program.

2. I understand that I will be expected to participate in one ____personal or ____ group interview with Dr. Huyck, requiring approximately ____ one hour ___ two hours of my time. I will be asked to make ratings assessing characteristics of the Residents and the program.

3. I understand that the information gathered in this study may be published in professional journals or presented in scientific meetings in an amalgamated fashion in which my personal identity will be concealed. I also understand that the data will be coded to insure that my own name does not appear on records accessible to the public or to future employers.

4. I understand that I will not be asked to do anything during this study which should cause or increase any personal discomfort.

5. I understand that my participation in this research project is voluntary and that I may withdraw from the study at any time without prejudice.

6. Any questions I have about the research and my rights as a participant can be answered by contacting the project director, (Margaret Huyck, Ph.D., 567-3617) in the Life Science Building, IIT Center, or the Executive Officer of the IIT Institutional Review Board, Barbara Calabrese 567-3035. I am aware that IIT is not responsible for any injuries not due to negligence that may be sustained by me during the course of the research. This research has been approved by the Review Board at Evanston Hospital, under the supervision of Bernard Adelson, M.D.

7. I have read the material above and any questions have been answered to my satisfaction. I have been provided with a copy of this consent form for my records.

---------------------------------------------------------------- ------------------------------

**Respondent's Signature** **Date**

---------------------------------------------------------------- ------------------------------

**Project Director's Signature** **Date**

Date: ______________________ Interviewer: ________________

## INTERVIEW FOR MEDICAL RESIDENTS

*Margaret H. Huyck: 6/14/91*

Introduction You have participated in a new program as part of your geriatric residency rotation at the Evanston Hospital. For the first time this past year, medical residents have been scheduled to attend the North Shore Senior Center in Winnetka for one-half day a week. Since this is a new program, the persons who designed and carry out this program are very interested in finding out how effective the program is. The NSSC applied for a special grant from the Gerontological Society to get the services of an expert to evaluate the program; I was selected. Today I want to talk with you about your experiences in geriatric medicine and your observations on the NSSC part of your geriatric training.

You have been assigned a case number; this number only will be attached to your responses. This is done to protect the confidentiality of what you say here. In order to evaluate the program, it is important to have your candid assessments. However, in reporting your observations, you will not be identified personally, and individuals you mention will not be named.

Because it is very important to understand exactly what you mean, I will be writing your answers verbatim.

A standard part of participating in research includes signing an Informed Consent form. This is the form; please read it and sign it before we begin. *(Give form, and provide copy for respondent.)*

1. Do you have any questions of me before we begin?

## II. GOAL BEHAVIORS

A. Patient Discussion One of the things we are interested in is how you approach your older patients. Some of the mentor physicians put together this "sample patient", describing an older woman patient. After you read the patient description, I have some questions for you.
*Give Resident the patient description.*

2. What diagnostic possibilities come to mind in this case?

**Code: 0 = not mentioned; 1 = prompted; 2 = spontaneously mentioned**

| | | |
|---|---|---|
| **2.1** | **Small-stroke syndrome/multi-infarct dementia** | **0 1 2** |
| **2.2** | **Subdural hematoma** | **0 1 2** |
| **2.3** | **Alcohol amnestic disorder** | **0 1 2** |
| **2.4** | **Alzheimer's type dementia** | **0 1 2** |
| **2.5** | **Caregiver stress syndrome** | **0 1 2** |
| **2.6** | **Elder abuse** | **0 1 2** |
| **2.7** | **Inappropriate medication use or lack thereof** | **0 1 2** |

# NSSC/EH GERIATRIC EDUCATION PROGRAM EVALUATION

## Patient Discussion

An 81-year old woman is brought in to your office, accompanied by her daughter, because of general decline. The daughter states that she has taken care of her mother in her own home for the past nine years since the patient's husband died suddenly. The woman has had mild "senility" for several years, but in the last few months she has suddenly become increasingly forgetful. She has occasionally left food burning on the stove when left alone. She gets up at night, at times agitated and screaming, and attempts to leave the house to look for her husband. She has fallen several times. She now needs help with bathing and dressing.

She has a history of hypertension and mild congestive heart failure. She takes hydrochlorthiazide, potassium, digoxin and enalspril. She does not complain of chest pain or shortness of breath. She occasionally drinks alcohol, which the daughter has in the house.

The daughter would like you to recommend a way to control her mother's nocturnal behavior. She would like to "avoid a lot of tests" because of limited finances. She was divorced last year at age 54, and had to quit her part-time job when her mother began deteriorating. Her brother and sister live in another state. Her children are married but try to help when possible.

On exam, the patient is disoriented and somewhat anxious, but in no acute distress. BP 170/100; P 70 and regular. General exam is remarkable only for an S 4 and some scattered ecchymoses on her shoulders, back and arms, in various stages of healing. Neurologic exam shows no focal abnormalities. She has a normal gait and balance exam and negative Romberg. Folstein Mini-Mental score = 22/30.

**Labs:** CBC, T4, TSH, B12, folate, PT, PTT, platelets, bleed time - WNL.

SMAC - WNL except LDH 240. Digoxin < 0.5.

3. What further steps can be taken to evaluate these possibilities? (PROBE: What would you want to find out about the family and home situation before you decided on a treatment plan?)

**Code: 0 = not mentioned; 1 = prompted; 2 = spontaneously mentioned**

**3.1 CT or MRI scan 0 1 2**
**3.2 Discuss with patient privately how she got bruises 0 1 2**
**3.3 Discuss with daughter privately whether she is feeling undue stress 0 1 2**
**3.4 Give daughter permission to meet own needs 0 1 2**
**3.5 Provide information on caregiver stress 0 1 2**
**3.6 Suggest investigating options for respite care 0 1 2**
**3.7 Discuss ways to maximize mom's functioning 0 1 2**
**3.8 Home assessment for safety 0 1 2**
**3.9 Home assessment for medication check 0 1 2**
**3.10 Home assessment for environmental barriers 0 1 2**
**3.11 Home assessment for social isolation 0 1 2**

B. Communication Skills

4. Many older persons have some hearing impairments. If you suspect, or know, that you are communicating with a person with a hearing impairment, how do you alter your behavior?

**Code: 0 = not mentioned; 1 = prompted; 2 = spontaneously mentioned**

**4. 1 Don't yell; speak in natural manner. 0 1 2**
**4. 2 Distance 3-6 feet 0 1 2**
**4. 3 Never speak directly into person's ear. 0 1 2**
**4. 4 Do not speak from another room. 0 1 2**
**4. 5 Rephrase misunderstood messages; don't just repeat. 0 1 2**
**4. 6 Simplify complex or lengthy messages. Use short simple sentences. 0 1 2**
**4. 7 Inform of topic before speaking; alert to changes of topic. 0 1 2**
**4. 8 Do not exaggerate sounds when speaking. 0 1 2**
**4. 9 Do not drop voice at end of a statement. 0 1 2**
**4.10 Speak at normal rate. 0 1 2**
**4.11 Keep hands and objects away from face. 0 1 2**
**4.12 Avoid speaking while eating, chewing, smoking, smiling, etc. 0 1 2**
**4.13 Get patient's attention first, and be sure she can see your face. 0 1 2**
**4.14 Limit environmental noise; move is necessary to quiet place. 0 1 2**
**4.15 Arrange environment so speaker's face and body can be seen. 0 1 2**
**4.16 If not wearing hearing aid, encourage use. 0 1 2**
**4.17 Position self to maximal lights shines on your face. 0 1 2**
**4.18 Have person verify information to make sure he/she understands. 0 1 2**

5. Some older patients suffer with dementia. Communicating with these patients is often a major challenge for physicians. How do you alter your normal communication style when you are dealing with a person who has mild to severe dementia?

**Code: 0 = not mentioned; 1 = prompted; 2 = spontaneously mentioned**

| | | |
|---|---|---|
| **5. 1** | **Approach from the front; get and maintain eye contact.** | **0 1 2** |
| **5. 2** | **Say person's name and identify yourself.** | **0 1 2** |
| **5. 3** | **Say message in simplest terms.** | **0 1 2** |
| **5. 4** | **State ideas in positive rather than negative terms.** | **0 1 2** |
| **5. 5** | **Avoid questions.** | **0 1 2** |
| **5. 6** | **Break tasks into simplest parts, and give directions one step at a time.** | **0 1 2** |
| **5. 7** | **Avoid baby talk.** | **0 1 2** |
| **5. 8** | **Use non-verbal communication.** | **0 1 2** |
| **5. 9** | **Speak more slowly than normal.** | **0 1 2** |
| **5.10** | **Smile and use your sense of humor.** | **0 1 2** |
| **5.11** | **Don't apply reason and logic.** | **0 1 2** |
| **5.12** | **Never ask, "Don't you remember?"** | **0 1 2** |
| **5.13** | **Never speak in front of them as if they are not there.** | **0 1 2** |
| **5.14** | **Never assume they don't know or understand.** | **0 1 2** |
| **5.15** | **Don't confront hallucinations or delusions with reality.** | **0 1 2** |
| **5.16** | **Include a person who is familiar with the patient in conference.** | **0 1 2** |
| **5.17** | **Write things down.** | |

6. Sometimes it is difficult to know whether your communication has been clear. How do you check whether your intended message has gotten through to your older patients?

**Code: 0 = Not mentioned; 1 = prompted; 2 = spontaneously mentioned**

| | | |
|---|---|---|
| **6.1** | **Rephrase the question and look for signs of understanding.** | **0 1 2** |
| **6.2** | **Ask patient how she/he can apply the information.** | **0 1 2** |
| **6.3** | **Ask patient whether she/he has any questions.** | **0 1 2** |

## C. Resource Familiarity

One of the goals of this part of the geriatric education program was to help you become more familiar with the kinds of community programs and resources that are available to physicians trying to arrange for the full healthcare needs of their older patients. The NSSC offers many of these services, and has information available about many others. I have some questions about your familiarity with such services.

7. Did you read the information in the yellow packet provided by the NSSC?

**7.1 Code: No = 0 Some of it = 1 All of it = 2**

8. How did you find the Community Guide? **Code: Didn't read = 0;**

9. For each of the following programs, please indicate (1) whether you have heard of the program; (2) whether you feel comfortable with your knowledge of what services are available; and (3) whether you know where you could refer someone who wanted information about the service. **Code: 0 = not at all; 1 = somewhat ; 2 = fairly familiar; 3 = quite familiar; 4 = very**

| | | Heard Of | Familiar | Info Source |
|---|---|---|---|---|
| 9.1 | Senior Centers | | | |
| 9.2 | Adult Day Care | | | |
| 9.3 | Chore Services | | | |
| 9.4 | Elder abuse | | | |
| 9.5 | Support Groups | | | |
| 9.6 | Counseling and Case Management | | | |
| 9.7 | Information on nursing homes | | | |
| 9.8 | Legal counsel | | | |
| 9.9 | Home care and meals | | | |
| 9.10 | Sick-room supplies | | | |
| 9.11 | Volunteer opportunities | | | |
| 9.12 | Friendly visiting and telephone care | | | |
| 9.13 | Adult education opportunites | | | |
| 9.14 | Financial assistance | | | |
| 9.15 | Employment for seniors | | | |
| 9.16 | Housing (not nursing home) | | | |
| 9.17 | Home-delivered library books | | | |
| 9.18 | Transportation for seniors | | | |
| 9.19 | Dental care for homebound | | | |
| 9.20 | Alzheimer's Disease information | | | |

10. Have you used any of these services, or referred anyone to them? Tell me about that. (Probes: If have not used any services, why--ignorance, not job, etc.)

D. Self Evaluation of Skills in Program Goal Behaviors

11. As you may have gathered, the collaborative program between NSSC and EH was designed to meet certain educational goals. I am going to describe some of these goals to you, and ask you to rate yourself on these dimensions. First, I will ask you to think back before you started your geriatric rotation, and rate yourself as of then. Second, think about now, after you have completed your geriatric rotation. And finally, I will ask you to think about how skillful you will be in another 5 years.

In making your ratings, use the following scale from 1 to 5:

1 = Realistically, I was (or am now) not comfortable with these issues. I don't know enough to feel competent in including these into my medical practice.

3 = I'm reasonably competent in these areas, but at least some of the time I feel unsure about what to consider or do. I have a general idea of how to incorporate these into my medical practice.

5 = I am very confident that I have included these aspects into my medical practice. I would feel comfortable modeling these behaviors for others.

| BEHAVIORS | BEFORE | NOW | +5 YRS |
|---|---|---|---|

---

11.1 Sensitivity to psychosocial issues in health:

Can you think of an example to illustrate your current rating?

---

11.2 Appreciation of caregiver concerns.

Example illustrating rating:

---

11.3 Appropriate communication skills for seniors.

Example illustrating rating:

---

11.4 Awareness of supportive services.

Example illustrating rating:

## III. THE ROUTE TO GERIATRICS

### A. General Expectations

12. Why did you select the geriatric rotation as part of your Residency program?

13. Who do you think should take a rotation in geriatric medicine? [PROBE: internists only, or specialists as well] What makes that reasonable?

14. How do you feel now about geriatric medicine? What are the attractions and problems with this kind of practice, from you current perspective?

### B. The NSSC Experience

15. Before you went to the NSSC, what did you expect to gain from your time there? On what did you base your expectations?

16. The NSSC - EH Geriatric Wellness Center offered residents opportunities to participate in several services. Which of the following did you participate in at NSSC? Any others? [list]

**Code: 0 = Did not participate; 1 = once ; 2 = twice; 3; 4; 9 = can't recall**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 16.1 | Home Assessment visit with social worker/case manager | **0** | **1** | **2** | **3** | **4** | **9** |
| 16.2 | Parkinson's Program | **0** | **1** | **2** | **3** | **4** | **9** |
| 16.3 | House of Welcome | **0** | **1** | **2** | **3** | **4** | **9** |
| 16.4 | Hard of Hearing Services | **0** | **1** | **2** | **3** | **4** | **9** |
| 16.5 | Wellness Clinic consultations | **0** | **1** | **2** | **3** | **4** | **9** |

In how many half-day sessions did you participate? _________

## III. PROGRAM ASSESSMENT: MEETING STATED GOALS

### A. Increasing sensitivity to psychosocial aspects of health and illness

17. What experiences in this program helped you develop these skills?

18. What experiences or aspects of the program hindered your development?

19. How would you modify the program to improve the chances that residents would develop the desired competencies?

### B. Increasing understanding of caregiver concerns and needs

20. What experiences in this program helped you develop these understandings?

21. What experiences or aspects of the program limited your development in this?

22. How would you modify the program to improve learning in this area?

C. Developing communication skills appropriate to enhancing the health care of elderly persons and their families, including those with hearing or cognitive impairments

23. What experiences in this program helped you develop such skills?

24. What has limited your developing these skills?

25. How would you modify the program to improve such skill mastery?

D. Increased awareness of community services available to support health care

26. What has helped you develop this knowledge?

27. What factors have limited your learning about these services?

28. How would you modify the program to ensure that all residents acquired this knowledge?

## V. PROGRAM ASSESSMENT: OTHER ASPECTS

A. The NSSC-EH component While we have been talking about some specific aspects of the program established by the NSSC and Evanston Hospital, we are also interested in other aspects of your experiences in this program. Sometimes the most important "learnings" are incidental, like observing a mentor physician do something particularly good, or testing yourself in a strange situation and finding you can cope, or discovering that other professionals can be very helpful to you in helping you practice excellent medicine. Thinking now about all the contacts and experiences you had during your times with the NSSC:

29. What were the most valuable aspects for you?

30. And what components do you think should be dropped?

31. In addition to those mentioned before, are there other features of the program which should be modified in order to improve the learning experience?

32. What experiences would you like to see added to the program?

33. A distinctive feature of this program involves close collaboration with social workers. How do you feel about this collaboration in your future medical practice?

34. You have worked with several senior mentor-physicians as part of this program. In what ways have these physicians contributed to your learning in this component?

35. What could the mentor physicians do to improve the learning situation for the residents?

B. In the context of the total geriatric rotation The primary focus has clearly been on a relatively small component of your month-long geriatric rotation. The NSSC program was designed to include one-tenth of your time -- one half day a week -- which is a very brief time in which to accomplish some of the goals established. Think now about your overall geriatric rotation, and put the experiences with the NSSC in that wider context.

36. In what ways does the NSSC component offer something distinctive?

37. Would you recomend increasing, decreasing, or leaving the amount of time spent at the NSSC? What makes that recommendation seem right?

## V. SUMMARY EVALUATIONS

38. Personal Attitudes Questionnaire [give to respondent to complete]

39. Is there anything else we should know about your experiences in this program to understand how you feel?

Thank you for your cooperation. Please do not discuss this interview with any of the other residents. We are interested in getting each person's personal responses; after we complete the study we will send you a report and you can discuss it at that point.

## PERSONAL ATTITUDES QUESTIONNAIRE

Please read the statements below, and indicate the extent to which you agree or disagree with them. Obviously, there are no right or wrong answers; your candid observations are of interest.

Put an **X** through the number that best corresponds to your thoughts. Use the following guide:

**1 = Disagree strongly with this statement**
**2 = Disagree somewhat with this statement**
**3 = Ambivalent or indifferent**
**4 = Agree somewhat with statement**
**5 = Agree strongly with statement**

**Disagree** **Agree**

1. I feel fortunate to have participated in the NSSC pilot program. 1 2 3 4 5
2. The NSSC/EH program is a good idea for geriatric education. 1 2 3 4 5
3. The program was well designed to meet the goals. 1 2 3 4 5
4. Geriatric medicine is an intellectually challenging specialty. 1 2 3 4 5
5. Treating older patients means you seldom get the satisfaction of really helping someone get well. 1 2 3 4 5
6. The NSSC experiences should be a larger part of the rotation. 1 2 3 4 5
7. I will encourage others to elect the geriatric rotation. 1 2 3 4 5
8. My mentor geriatric physicians were good role models. 1 2 3 4 5
9. An internist has too many medical things to learn to bother about becoming familiar with community resources and family functioning. 1 2 3 4 5
10. I enjoy working with older patients. 1 2 3 4 5
11. Even if there are a lot of old people who need medical care, I hope that some other physicians will treat them. 1 2 3 4 5
12. It's frustrating to treat older patients because they have so many problems. 1 2 3 4 5
13. I plan to collaborate with social workers in treating older people. 1 2 3 4 5
14. My interest in geriatrics has decreased since my rotation. 1 2 3 4 5
15. I intend to specialize in geriatric medicine. 1 2 3 4 5

### FIELD NOTES

Date ______________________________ Time ________________________________

Setting: ____________________________________________________________________________

Willing to be recontacted for additional information? ____________

Wants feedback on study? ____________________________________

Date: ______________________ Interviewer: ________________

## INTERVIEW FOR MENTOR PHYSICIANS

*Margaret H. Huyck: 6/5/91*

Introduction You have participated in a new program as part of your geriatric practice at the Evanston Hospital. For the first time this past year, medical residents have been scheduled to attend the North Shore Senior Center in Winnetka for one-half day a week. Since this is a new program, the persons who designed and carry out this program are very interested in finding out how effective the program is. The NSSC applied for a special grant from the Gerontological Society to get the services of an expert to evaluate the program; I was selected. Today I want to talk with you about your assessments of the residents you have seen go through this program in geriatric medical education, your observations on the NSSC part of the geriatric training, and a little about your own experiences in geriatric medicine.

You have been assigned a case number; this number only will be attached to your responses. This is done to protect the confidentiality of what you say here. In order to evaluate the program, it is important to have your candid assessments. However, in reporting your observations, you will not be identified personally, and individuals you mention will not be named.

Because it is very important to understand exactly what you mean, I will be writing your answers verbatim.

A standard part of participating in research includes signing an Informed Consent form. This is the form; please read it and sign it before we begin. *(Give form, and provide copy for respondent.)*

1. Do you have any questions of me before we begin?

## I. EXPERT EVALUATION OF RESIDENT ON GOAL BEHAVIORS R 1

The collaborative program between NSSC and EH was designed to meet certain educational goals. I am going to remind you of some of these goals, and ask you to rate each of the medical residents you supervised on these dimensions.

Right now, please think about all your observations of: ______________________

In making your ratings, use the following scale from 1 (undeveloped) to 5 (well developed):

1 = This resident does not seem comfortable with these issues. There is very little evidence in their behavior that indicates that he/she is able to include the desirable behaviors into their medical practice.

3 = This resident seems reasonably competent in these areas, but some of the time she/he seems unsure about what to consider or do. Desirable behaviors are evident about half of the time.

5 = This resident physician has clearly developed competence in these aspects of medical practice. Desirable behaviors are consistently evident, and I think she/he understands them well enough to act as a mentor to others and explain the rationale for the behaviors.

| BEHAVIORS | RATING |
|---|---|

1.1 Sensitivity to psychosocial issues in health and illness.

Can you think of examples to illustrate your rating?

---

1.2 Appreciation of caregiver concerns.

Examples illustrating rating:

---

1.3 Appropriate communication skills for seniors, including those with hearing or cognitive impairments:

Example illustrating rating:

---

1.4 Awareness of supportive services.

Example illustrating rating:

## II. ON ROUTE TO GERIATRICS P 2

### A. General Expectations

2. Why did you elect to participate as a mentor physician in this program?

3. Who do you think should take a rotation in geriatric medicine? [PROBE: internists only, or specialists as well] What makes that reasonable?

4. How do you feel now about geriatric medicine? What are the attractions and problems with this kind of practice, from you current perspective?

### B. The NSSC Experience P 5

5. Before you participated in the NSSC program, what did you expect to gain from your time there? On what did you base your expectations?

6. The NSSC - EH Geriatric Wellness Center offered you and the residents opportunities to participate in several services. Which of the following did you participate in at NSSC? Any others? [list]

**Code: 0 = Did not participate; 1 = once ; 2 = twice; 3; 4; 9 = can't recall**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.1 | Home Assessment visit with social worker/case manager | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| 6.2 | Parkinson's Program | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| 6.3 | House of Welcome | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| 6.4 | Hard of Hearing Services | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| 6.5 | Wellness Clinic consultations | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |

In how many half-day sessions did you participate? __________

## III. PROGRAM ASSESSMENT: MEETING STATED GOALS **P 6**

A. Increasing sensitivity to psychosocial aspects of health and illness

7. What experiences in this program do you think helped develop these skills?

8. What experiences or aspects of the program hindered the development?

9. How would you modify the program to improve the chances that residents would develop the desired competencies?

B. Increasing understanding of caregiver concerns and needs

10. What experiences in this program helped to develop these understandings?

11. What experiences or aspects of the program limited the development in this?

12. How would you modify the program to improve learning in this area?

C. Developing communication skills appropriate to enhancing the health care of elderly persons and their families, including those with hearing or cognitive impairments

13. What experiences in this program helped residents develop such skills?

14. What has limited the development of these skills?

15. How would you modify the program to improve such skill mastery?

D. Increased awareness of community services available to support health care

16. What has helped residents develop this knowledge?

17. What factors have limited learning about these services?

18. How would you modify the program to ensure that all residents acquired this knowledge?

## V. PROGRAM ASSESSMENT: OTHER ASPECTS P 10

A. The NSSC-EH component While we have been talking about some specific aspects of the program established by the NSSC and Evanston Hospital, we are also interested in other aspects of your experiences in this program. Sometimes the most important "learnings" are incidental, like developing a different kind of mentor relationship, or seeing your junior colleagues discover that other professionals can be very helpful in learning to practice excellent medicine. Thinking now about all the contacts and experiences you had during your times with the NSSC:

19. What do you think are the most valuable aspects of the program?

20. And what components do you think should be dropped?

21. In addition to those mentioned before, are there other features of the program which should be modified in order to improve the learning experience?

22. What experiences would you like to see added to the program?

23. A distinctive feature of this program involves close collaboration with social workers. How do you feel about this emphasis as a part of the medical education at this level?

B. In the context of the total geriatric rotation The primary focus has clearly been on a relatively small component of your month-long geriatric rotation. The NSSC program was designed to include one-tenth of the resident's time -- one half day a week -- which is a very brief time in which to accomplish some of the goals established. Think now about the overall geriatric rotation, and put the experiences with the NSSC in that wider context.

24. In what ways does the NSSC component offer something distinctive?

25. Would you recomend increasing, decreasing, or leaving the amount of time spent at the NSSC? What makes that recommendation seem right?

## II. SUMMARY EVALUATIONS

26. Personal Attitudes Questionnaire [give to respondent to complete]

27. Is there anything else we should know about your experiences in this program to understand how you feel?

**NSSC/EH GERIATRIC PROGRAM** **Code Number** ____________________

**P 12**

## PERSONAL ATTITUDES QUESTIONNAIRE

*Mentor Physicians*

Please read the statements below, and indicate the extent to which you agree or disagree with them. Obviously, there are no right or wrong answers; your candid observations are of interest.

Put an **X** through the number that best corresponds to your thoughts. Use the following guide:

**1 = Disagree strongly with this statement**
**2 = Disagree somewhat with this statement**
**3 = Ambivalent or unsure**
**4 = Agree somewhat with statement**
**5 = Agree strongly with statement**

| | | **Disagree** | | | | **Agree** |
|---|---|---|---|---|---|---|
| 1. | I feel fortunate to have participated in the NSSC pilot program. | 1 | 2 | 3 | 4 | 5 |
| 2. | The NSSC/EH program is a good idea for geriatric education. | 1 | 2 | 3 | 4 | 5 |
| 3. | The program was well designed to meet the goals. | 1 | 2 | 3 | 4 | 5 |
| 4. | Geriatric medicine is an intellectually challenging specialty. | 1 | 2 | 3 | 4 | 5 |
| 5. | Treating older patients means you seldom get the satisfaction of really helping someone get well. | 1 | 2 | 3 | 4 | 5 |
| 6. | The NSSC experiences should be a larger part of the rotation. | 1 | 2 | 3 | 4 | 5 |
| 7. | I will encourage others to elect the geriatric rotation. | 1 | 2 | 3 | 4 | 5 |
| 8. | Serving as a mentor physician has been a good use of my time. | 1 | 2 | 3 | 4 | 5 |
| 9. | An internist has too many medical things to learn to bother about becoming familiar with community resources and family functioning. | 1 | 2 | 3 | 4 | 5 |
| 10. | I enjoy working with older patients. | 1 | 2 | 3 | 4 | 5 |
| 11. | Even if there are a lot of old people who need medical care, I hope that some other physicians will treat them. | 1 | 2 | 3 | 4 | 5 |
| 12. | It's frustrating to treat older patients because they have so many problems. | 1 | 2 | 3 | 4 | 5 |
| 13. | I try to collaborate with social workers in treating older people. | 1 | 2 | 3 | 4 | 5 |
| 14. | My interest in geriatrics has decreased in the past five years. | 1 | 2 | 3 | 4 | 5 |
| 15. | I consider myself a specialist in geriatric medicine. | 1 | 2 | 3 | 4 | 5 |

## FIELD NOTES

Date ______________________________ Time ________________________________

Setting: ____________________________________________________________

Willing to be recontacted for additional information? ____________

Wants feedback on study? ____________________________________

**NSSC/EH GERIATRIC EDUCATION PROGRAM EVALUATION** **P**

Date: ______________________ Interviewer: ________________

## INTERVIEWS WITH NSSC STAFF

*Margaret H. Huyck: 7/5/91*

Introduction You have participated in a new program educating physicians in geriatric medicine at the Evanston Hospital. For the first time this past year, medical residents have been scheduled to attend the North Shore Senior Center in Winnetka for one-half day a week. Since this is a new program, the persons who designed and carry out this program are very interested in finding out how effective the program is. The NSSC applied for a special grant from the Gerontological Society to get the services of an expert to evaluate the program; I **[or, Margaret Huyck]** was selected.

**[First session]** Today, I want to talk with you about your assessments of the residents you have seen go through this program in geriatric medical education. We will discuss each of the residents, and then ask each of you who feel familiar enough with the resident to make your own rating of the resident's competence in particular kinds of behaviors. At some future time, we will schedule personal interviews with Dr. Mary Doi.

All the interviews are done confidentially, though the fact that this is a group interview means that persons who are present will, obviously, know what you have to say. However, the same principles of confidentiality apply to this proceeding as to others: what is said here will remain confidential, confined to this group, and not discussed outside the group present. This is done to protect the confidentiality of what you say here. In order to evaluate the program, it is important to have your candid assessments. However, in reporting your observations, you will not be identified personally, and individuals you mention will not be named.

Because it is very important to understand exactly what you mean, I will be recording this session, as well as writing your answers verbatim.

A standard part of participating in research includes signing an Informed Consent form. This is the form; please read it and sign it before we begin. *(Give form, and provide copy for respondent.)*

### Session 1: Group Discussion and Rating of Resident Physicians

1. Do you have any questions of me before we begin?

**NSSC/EH GERIATRIC PROGRAM** **Code Number** ________________

## I. EXPERT EVALUATION OF RESIDENTS ON GOAL BEHAVIORS R 1

The collaborative program between NSSC and EH was designed to meet certain educational goals. I am going to remind you of some of these goals, and ask you to rate each of the medical residents you supervised on these dimensions.

Right now, please think about all your observations of: ________________________

In making your ratings, use the following scale from 1 (undeveloped) to 5 (well developed):

1 = This resident does not seem comfortable with these issues. There is very little evidence in their behavior that indicates that he/she is able to include the desirable behaviors into their medical practice.

3 = This resident seems reasonably competent in these areas, but at least some of the time she/he seems unsure about what to consider or do. Desirable behaviors are evident about half of the time.

5 = This resident physician has clearly developed competence in these aspects of medical practice. Desirable behaviors are consistently evident, and I think she/he understands them well enough to act as a mentor to others and explain the rationale for the behaviors.

**BEHAVIORS** **RATINGS** **MEAN**

------------------------------------------------------------------------------------------------------------

**2.1 Sensitivity to psychosocial issues in health and illness.**

**1 =** ________ **2 =** _______ **3 =** _______ **4 =** _______ **5 =** _______

Can you think of examples to illustrate your rating?

2.2 Appreciation of caregiver concerns.

**1 =** ________ **2 =** _______ **3 =** _______ **4 =** _______ **5 =** _______

Examples illustrating rating:

2.3 Appropriate communication skills for seniors, including those with hearing or cognitive impairments:

**1 =** ________ **2 =** _______ **3 =** _______ **4 =** _______ **5 =** _______

Examples illustrating rating:

2.4 Awareness of supportive services.

**1 =** ________ **2 =** _______ **3 =** _______ **4 =** _______ **5 =** _______

Examples illustrating rating:

**NSSC/EH GERIATRIC PROGRAM** **Code Number** ____________________

Session 2: Individual Interview

**[Second session]** A while ago, the NSSC staff got together and rated each of the medical residents on their competence in the behaviors that this program was designed to develop. Today we want to find out more about your own observations on the NSSC part of the geriatric training program. You will have a code number, and whatever you say will remain confidential. Because it is very important to understand exactly what you mean, I will be writing your answers verbatim. Since this is a different format, we need another consent.

1. Do you have any questions of me before we begin?

## II. PROGRAM ASSESSMENT: MEETING STATED GOALS P 2

Please think now about your own participant observations of residents and mentor physicians participating in the NSSC program; think also about your own participation in the program, and how it may impact on what you usually do. I have some questions about the ways you think the program functions in terms of the stated goals of the program.

2. What contacts have you had with residents and mentor physicians?

A. Increasing sensitivity to psychosocial aspects of health and illness

3. What experiences in this program do you think helped residents develop these skills?

4. What experiences or aspects of the program hindered the development?

5. How would you modify the program to improve the chances that residents would develop the desired competencies?

B. Increasing understanding of caregiver concerns and needs

6. What experiences in this program helped residents to develop these understandings?

7. What experiences or aspects of the program limited the development in this?

8. How would you modify the program to improve learning in this area?

C. Developing communication skills appropriate to enhancing the health care of elderly persons and their families, including those with hearing or cognitive impairments

9. What experiences in this program helped residents develop such skills?

10. What has limited the development of these skills?

11. How would you modify the program to improve such skill mastery?

D. Increased awareness of community services available to support health care

12. What has helped residents develop this knowledge?

13. What factors have limited learning about these services?

14. How would you modify the program to ensure that all residents acquired this knowledge?

## III. PROGRAM ASSESSMENT: OTHER ASPECTS P 13

A. The NSSC-EH component While we have been talking about some specific aspects of the program established by the NSSC and Evanston Hospital, we are also interested in other aspects of your experiences in this program. Sometimes the most important "learnings" are incidental, like developing a different kind of professional relationship. Thinking now about all the contacts and experiences you had during your times with the NSSC/EH program:

15. What do you think are the most valuable aspects of the program?

16. And what components do you think should be dropped?

17. In addition to those mentioned before, are there other features of the program which should be modified in order to improve the learning experience?

18. What experiences would you like to see added to the program?

19. A distinctive feature of this program involves close collaboration with social workers. How do you feel about this emphasis as a part of the medical education at this level?

## IV. SUMMARY EVALUATIONS

20. Personal Attitudes Questionnaire [give to respondent to complete]

21. Is there anything else we should know about your experiences in this program to understand how you feel?

### FIELD NOTES

Date ____________________ Time ____________________

Setting: ________________________________________

Willing to be recontacted for additional information? __________

Wants feedback on study? ____________________

Other observations about interaction:

**NSSC/EH GERIATRIC PROGRAM** **Code Number** ____________________

**P 19**

## PERSONAL ATTITUDES QUESTIONNAIRE
*NSSC Professionals*

Please read the statements below, and indicate the extent to which you agree or disagree with them. Obviously, there are no right or wrong answers; your candid observations are of interest.

Put an **X** through the number that best corresponds to your thoughts. Use the following guide:

**1 = Disagree strongly with this statement**
**2 = Disagree somewhat with this statement**
**3 = Ambivalent or unsure**
**4 = Agree somewhat with statement**
**5 = Agree strongly with statement**

|  | **Disagree  Agree** |
|---|---|
| 1. I feel fortunate to have participated in the NSSC pilot program. | 1 2 3 4 5 |
| 2. The NSSC/EH program is a good idea for geriatric education. | 1 2 3 4 5 |
| 3. The program was well designed to meet the goals. | 1 2 3 4 5 |
| 4. Geriatric practice is an intellectually challenging specialty. | 1 2 3 4 5 |
| 5. Treating older patients means you seldom get the satisfaction of really helping someone function more effectively. | 1 2 3 4 5 |
| 6. The NSSC experiences should be a larger part of the rotation. | 1 2 3 4 5 |
| 7. I think all internists should take a geriatric rotation. | 1 2 3 4 5 |
| 8. Serving as a mentor to the physicians has been a good use of my time. | 1 2 3 4 5 |
| 9. An internist has too many medical things to learn to bother about becoming familiar with community resources and family functioning. | 1 2 3 4 5 |
| 10. I enjoy working with older patients. | 1 2 3 4 5 |
| 11. Even if there are a lot of old people who need care, I hope that someone else will care for them. | 1 2 3 4 5 |
| 12. It's frustrating to work with older patients because they have so many problems. | 1 2 3 4 5 |
| 13. I try to collaborate with physicians in treating older people. | 1 2 3 4 5 |
| 14. My interest in gerontology has decreased in the past five years. | 1 2 3 4 5 |
| 15. I consider myself a specialist in gerontological practice. | 1 2 3 4 5 |

## Biographical Sketch

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VASSAR COLLEGE, A.B. 6/61: Sociology/Anthropology; Child Study/Education
UNIVERSITY OF CHICAGO, M.A. 6/63, Ph.D. 3/70, Committee on Human Development: Adult Development and Aging; Sociology of Education

Research:
"Aging parents, young adult children, and mental health," funded by National Institutes of Mental Health, Grant ROI MH3264, 1982-86

Selected Publications:
Huyck, M.H. (1974). **Growing Older: What You Need to Know About Aging.** Englewood Cliffs, N.J.: Prentice-Hall.

Huyck, M.H. (1978). Teaching the psychology of aging. In M. Seltzer, H. Sterns, & T. Hickey (Eds.), **Gerontology in Higher Education: Perspectives and Issues** (pp 219-223). Belmont, Ca: Wadsworth.

Huyck, M.H. & Hoyer, W.J. (1982). **Adult Development and Aging**. Belmont, Ca: Wadsworth.

Huyck, M.H. (1989) Models of midlife. In R. Kalish (Ed.), **Midlife Loss: Coping Strategies** (pp 10-34). Newbury Park, Ca: Sage.

Huyck, M.H. (1989). Gender differences in aging. In J. Birren & K.W. Schaie (Eds.), **Handbook of the Psychology of Aging** (3rd Ed) (pp 124-132). New York: Van Nostrand Reinhold.

Huyck, M.H. (1991) Gender-linked self-attributions and mental health during the middle years. **Journal of Aging Studies,** 5(1), 111-123.

Professional Associations
THE GERONTOLOGICAL SOCIETY OF AMERICA: Fellow; Sec/Treas BSS Section
AMERICAN PSYCHOLOGICAL ASSOCIATION: Member; Div 20 (Adult Development)